NAME: ______________________ Nickname: ______________ Date of Birth: ______________

ADDRESS: ______________________ City/State: ______________ Zip: __________

PHONE: Home ______________ Cell ______________ Work ______________

E-MAIL: ______________________________________

| Preferred Method of Contact: | | | | | |
|---|---|---|---|---|---|
| Appt. Confirmation | H | C | W | E-mail | |
| Recall | H | C | W | E-mail | Mail |
| Orders | H | C | W | E-mail | |

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**ROS** - Patient's Review of Systems: Check all that apply

**Constitution**
- Cancer
- Developmental Disorders
- Fatigue Syndrome
- Other

**ENT (Ears, Nose Throat)**
- Hearing Loss
- Sinusitis
- Laryngitis
- Dry Mouth
- Other

**Neurologic**
- Epilepsy
- Stroke/CVA
- Migraine
- Tumor
- MS
- Cerebral Palsy
- Other

**Psychologic**
- Attention Deficit
- Anxiety Disorder
- Depression
- Bipolar Disorder
- Other

**Cardiovascular**
- Hypertension
- Congestive Heart Failure
- Heart Disease
- Stroke/CVA
- Vascular Disease
- Other

**Respiratory**
- Emphysema
- Asthma
- Sleep Apnea
- Bronchitis
- Chronic Obstruction
- Other

**G I**
- Crohn's
- Ulcer
- Celiac Disease
- Colitis
- Acid Reflex
- Other

**Genitourinary**
- Herpes
- Prostate Disease
- Chlamydia
- STD
- Pregnant
- Other

**Muscular/Skeletal**
- Gout
- Ankylosing Spondylitis
- Fibromyalgia
- Osteoporosis
- Arthritis
- Muscular Dystrophy
- Other

**Integumentary (Skin)**
- Cold Sores
- Rosasea
- Shingles
- Psoriasis
- Eczema
- Other

**Endocrine**
- Diabetes Type 1
- Diabetes Type 2
- Thyroid Dysfunction
- Hormonal Dysfunction
- Other

**Hem/Lymph**
- Large Volume Blood Loss
- Hypercholesterol
- Ulcer
- Anemia
- Other

**Allergic/Immune**
- Drug Allergy -
- Rheumatoid Arthritis
- Sjogren's Syndrome
- Lupus
- Environmental Allergy

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**PAST OCULAR HISTORY:** Check all that apply

- Retinal Disease
- Strabismus - Eye Turn
- Dry Eye
- Glaucoma
- Surgery on Eye
- Injury
- Amblyopia
- Retinal Hole
- Keratoconus
- Age Related Macular Degeneration
- Patching
- Cataract
- Retinal Detachment
- Nystagmus
- Glaucoma Suspect
- Inflammatory - Iritis

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**MEDICATIONS:** List all

______________________________

______________________________

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**ALLERGIES:** List all

Meds. ______________________

Other ______________________

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**SOCIAL HISTORY**

| | | | |
|---|---|---|---|
| Drinking | Y | N | Amt. ______________ |
| Tobacco | Y | N | Type ______________ |

Hobbies: List ______________________________

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**FAMILY HISTORY:** Check all that apply

**Medical**
- Thyroid
- Diabetes
- Cancer

**Ocular**
- Severe Myopia
- Retinal Disease
- Glaucoma
- Macular Degeneration
- Nystagmus
- Severe Hyperopia
- Cataract
- Amblyopia
- Other

# HIPAA PRIVACY
# ACKNOWLEDGMENT OF RECEIPT
# OF
# NOTICE OF PRIVACY PRACTICES

I, ______________________________ (THE "PATIENT" OR LEGAL REPRESENTATIVE) HAVE BEEN PRESENTED WITH THE NOTICE OF PRIVACY PRACTICES OF GRANT R. SMITH, O.D. AND ASSOCIATES (THE "PROVIDER"), AND HAVE BEEN OFFERED A COPY OF SUCH POLICY TO KEEP FOR MY RECORDS.

INITIAL ONE BELOW

________ I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH A COPY OF THE POLICY.

________ I HEREBY REFUSE TO ACKNOWLEDGE RECEIPT OF THE POLICY. I UNDERSTAND THAT EVEN THOUGH I MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT, PROVIDER MAY STILL PROVIDE TREATMENT TO ME.

______________________________________________

SIGNATURE DATE

Having health and/or vision insurance DOES NOT guarantee payment in full of this examination. The policyholder is responsible for all copays, deductibles, coinsurance, and other uncovered/unpaid charges.

Signature: ____________________________________________ Date: __________________