NEWSOMEYE
You deserve NEWSOM EYES!

4211 US Highway 27 N, Sebring, FL 33870 (863) 385-1544
13904 N Dale Mabry Hwy, Suite 200, Tampa, FL 33618 (813) 908-2020
113 S. Armenia Ave., Tampa, FL 33609 (813) 908-2020
www.NEWSOMEYE.com

History of Present Illness

Name: _____ **Date**: _____
Please fill out this form as though you are wearing your glasses, if you currently have glasses.

Current Visual Complaints (circle all that apply):

Overall Decline in Vision	LEFT	RIGHT	BOTH
Blurry or Hazy Vision	LEFT	RIGHT	BOTH
Poor Night Vision	LEFT	RIGHT	BOTH
Rings or Halos Around Lights	LEFT	RIGHT	BOTH
Unbalanced Vision	LEFT	RIGHT	BOTH
Flashes	LEFT	RIGHT	BOTH
Floaters	LEFT	RIGHT	BOTH
Other:_____	LEFT	RIGHT	BOTH

If any complaints identified above, please check all that apply below:

Severity: _____ Mild _____ Moderate _____ Severe

Duration: _____ Days _____ Months _____ Years

Do you have difficulty with? (circle YES (**Y**) or NO (**N**) for each):

Y	**N**	Driving at Night
Y	**N**	Driving in the Daylight
Y	**N**	Reading Road Signs
Y	**N**	Reading Labels or Price Tags
Y	**N**	Using the Computer
Y	**N**	Glare or Sensitivity to Light
Y	**N**	Cooking
Y	**N**	Watching TV
Y	**N**	Doing Fine Work (like needle point)

Do your eyes experience the following? (circle YES (**Y**) or NO (**N**) for each):

Y	**N**	Feel Dry or Gritty
Y	**N**	Burn
Y	**N**	Over React to Smoke, Dust, or Light
Y	**N**	Tear or Water
Y	**N**	Feel Painful or Irritated

Other Comments: _____

Signature: _____

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Patient Medical History Questionnaire

Date: _____

Name: _____

Age: _____ **Sex**: M F **Weight**: _____ **Height**: _____ **Race**: _____

REVIEW OF SYSTEMS (please circle YES (**Y**) or NO (**N**) on the following health problems):

CARDIOVASCULAR
Y N Angina (last episode) _____
Y N Heart Attack (date) _____
Y N Heart Disease
Y N High Blood Pressure
Y N Stroke (date) _____

EARS / NOSE / THROAT
Y N Hearing Loss
Y N Wear Hearing Aids

ENDOCRINE
Y N Diabetes
Y N Thyroid

GASTROINTESTINAL
Y N Colitis/Diverticulitis
Y N Liver/Hepatitis
Y N Ulcers

GENITOURINARY
Y N Bladder
Y N Kidney
Y N Prostate

HEMATOLOGIC
Y N Anemia
Y N Bleed/Bruise Easily

MUSCULOSKELETAL
Y N Arthritis
Y N Joint Replacement

NEUROLOGIC / PSYCHIATRIC
Y N Alzheimer's
Y N Parkinson's Disease
Y N Seizures/Convulsions

RESPIRATORY
Y N Asthma
Y N Chest
Y N Lung Disease
Y N Tuberculosis

SKIN PROBLEMS
Y N Keloids/Scarring

OTHER
Y N Cancer (explain)_____
_____
_____

If you checked diabetes above, are you: ___ Diet-Controlled ___ Oral Medication-Controlled ___ Insulin-Controlled

PAST MEDICAL HISTORY: (please list any surgery, injuries, operations or hospitalizations other than eyes)

_____ _____ _____ _____

Please list all **MEDICATIONS** that you are currently taking including **EYEDROPS, VITAMINS, HERBS, MINERALS**

Medication	Strength	How Often	Medication	Strength	How Often

Are you allergic to any medications? **Y N** **LATEX SENSITIVITY/ALLERGY? Y N**

If yes, please list: _____ _____ _____

Are you allergic to IODINE? **Y N** *Are you allergic to SHELLFISH?* **Y N**

EYE HISTORY: (Check any that you have been diagnosed with)

_____ Cataracts _____ Diabetic Retinopathy _____ Macular Degeneration
_____ Corneal Problems _____ Glaucoma _____ Retinal Disorders

Eye Surgery / Eye Trauma (please list):

Right Eye: _____ _____ _____

Left Eye: _____ _____ _____

SOCIAL HISTORY

Occupation: _____ **Hobbies**: _____

Alcohol (Check which best applies): _____ None _____ Occasional/Social _____ 1-2 Drinks/day _____ 3-4 Drinks/day

Other (Please explain): _____

Smoking/Tobacco (Check which best applies): _____ Never smoker _____ Former Smoker _____ Current Everyday

_____ Current Some Day Smoker _____ Heavy Tobacco Smoker _____ Light Tobacco Smoker

Other (please explain): _____

Do you have a Power of Attorney? **Y N**

Living arrangement (Check which best applies) _____ Alone _____ with Spouse _____ with Family

FAMILY HISTORY

_____ Cancer _____ Glaucoma _____ Hypertension

_____ Diabetes _____ Heart Disease _____ Retinal Disorders

Other (please list): _____ _____ _____

In case of emergency: Next of Kin (not living with you) Name: _____

Phone: _____

PRIMARY MEDICAL PHYSICIAN

NAME: _____

ADDRESS: _____

_____

PHONE #: _____

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AGREEMENT AS TO RESOLUTION OF CONCERNS

I understand that I am entering into a contractual relationship with Daniel Ochs, Resident OD, Jessica Forde, OD, Mitchell Petit, OD, Eric Fazio, OD, Fayssal El-Jabali, DO, Kendra DeAngelis, MD, Vinita Srivastava, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Daniel Ochs, Resident OD, Jessica Forde, OD, Mitchell Petit, OD, Eric Fazio, OD, Fayssal El-Jabali, DO, Kendra DeAngelis, MD, Vinita Srivastava, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center. I agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against Daniel Ochs, Resident OD, Jessica Forde, OD, Mitchell Petit, OD, Eric Fazio, OD, Fayssal El-Jabali, DO, Kendra DeAngelis, MD, Vinita Srivastava, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center.

Should I initiate or pursue a meritorious medical malpractice claim Daniel Ochs, Resident OD, Jessica Forde, OD, Mitchell Petit, OD, Eric Fazio, OD, Fayssal El-Jabali, DO, Kendra DeAngelis, MD, Vinita Srivastava, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center for professional care. I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialists in the same or similar specialty Daniel Ochs, Resident OD, Jessica Forde, OD, Mitchell Petit, OD, Eric Fazio, OD, Fayssal El-Jabali, DO, Kendra DeAngelis, MD, Vinita Srivastava, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center. Further, I agree that these physicians retained by me or on my behalf to be an expert witness will be a member in good standing of the medical specialty society to which Daniel Ochs, Resident OD, Jessica Forde, OD, Mitchell Petit, OD, Eric Fazio, OD, Fayssal El-Jabali, DO, Kendra DeAngelis, MD, Vinita Srivastava, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center belongs. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by that physician's specialty society.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions. In further consideration Daniel Ochs, Resident OD, Jessica Forde, OD, Mitchell Petit, OD, Eric Fazio, OD, Fayssal El-Jabali, DO, Kendra DeAngelis, MD, Vinita Srivastava, MD, David Garruto, MD, T. Hunter Newsom, MD/Newsom Eye & Laser Center also agrees to exactly the same previously-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting evidence of a frivolous or meritless claim.

Patient and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Date of Signature: _____

Effective from Date of Treatment: _____

_____(Patient)

_____(Physician)

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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Acknowledgement of Receipt

By signing this document, I acknowledge that I have reviewed and/or requested a copy of the patient paperwork packet of Newsom Eye & Laser Center. This packet includes the following:

Please circle YES (Y) or NO (N) to applicable questions below.

- **Lifetime Authorization** (1st & 2nd Sections) – Medicare or Insurance Certification for Payment.
  - Do you belong to a Health Maintenance Organization (HMO)? **Y N**
  - Do you need approval for your Primary Care Physician (PCP) before you can be seen by an ophthalmologist/optometrist? **Y N**

- **Do we have permission to**:
  - Send a recall appointment reminder to your home **Y N**
  - Leave appointment, billing or treatment information on your voice mail, phone via text message or e-mail **Y N**
  - I give permission to share appointment, billing or treatment information with the person named below:

  Name: _____

- **Refraction(s)** – I understand that a portion of my examination is not covered by Medicare nor most insurance plans and do not include this as part of your integral exam (Refraction is $45.00)

- **Agreement as to Resolution of Concerns**
- **HIPAA Notice of Privacy Practice -** Disclosures of Protected Health Information

Print Name: _____

Signature: _____