

HISTORY OF PRESENT ILLNESS

NAME: _____ DATE: _____

CURRENT VISUAL COMPLAINTS: (circle all that apply)

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

SEVERITY: _____ Mild _____ Moderate _____ Severe

DURATION: _____ Days _____ Months _____ Years

DO YOU HAVE DIFFICULTY WITH: (circle all that apply)

YES	NO	Driving at Night
YES	NO	Driving in the Daylight
YES	NO	Reading Road Signs
YES	NO	Reading Labels or Price Tags
YES	NO	Using the Computer
YES	NO	Glare or Sensitivity to Light
YES	NO	Cooking
YES	NO	Watching TV
YES	NO	Doing Fine Work (like needle point)

DO YOUR EYES: (circle all that apply)

YES	NO	Feel Dry or Gritty
YES	NO	Burn
YES	NO	Over React to Smoke, Dust, or Light
YES	NO	Tear or Water
YES	NO	Feel Painful or Irritated

Other Comments: _____

Signature: _____



13904 N. Dale Mabry Hwy Ste. 200, Tampa, FL 33618 PH: (813) 908-2020
3205 Physicians Way, Sebring, FL 33870 PH: (863) 385-1544
1023 US Hwy 27 South, Avon Park, FL 33825 PH: (863) 452-0215
www.newsomeye.com

Patient Medical History Questionnaire

DATE: _____

NAME: _____ ACCT # _____

AGE: _____ SEX: M F WEIGHT: _____ HEIGHT: _____ RACE: _____

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

Grid of medical conditions for review: CARDIOVASCULAR, GASTROINTESTINAL, NEUROLOGIC / PSYCHIATRIC, EARS / NOSE / THROAT, ENDOCRINE, GENITOURINARY, HEMATOLOGIC, MUSCULOSKELETAL, RESPIRATORY, SKIN PROBLEMS, OTHER.

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

Table with 6 columns: Medication, Strength, How Often, Medication, Strength, How Often.

Are you allergic to any medications? ___ YES ___ NO LATEX SENSITIVITY/ALLERGY ___ YES ___ NO

If yes, please list: _____

Are you allergic to IODINE? ___ YES ___ NO

EYE HISTORY: (have you ever been diagnosed with)

Checkboxes for: Cataracts, Diabetic Retinopathy, Macular Degeneration, Corneal Problems, Glaucoma, Retinal Disorders.

Eye Surgery / Eye Trauma: (please list)

Right Eye: _____

Left Eye: _____

SOCIAL HISTORY

Occupation: _____ Alcohol: _____

Hobbies: _____ Smoking: _____

Do you live? _____ 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 # _____

REVIEWED BY: _____ DATE: _____ [] UPDATED [] NO CHANGE

REVIEWED BY: _____ DATE: _____ [] UPDATED [] NO CHANGE

REVIEWED BY: _____ DATE: _____ [] UPDATED [] NO CHANGE

REVIEWED BY: _____ DATE: _____ [] UPDATED [] NO CHANGE

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REVIEWED BY: _____ DATE: _____ [] UPDATED [] NO CHANGE

REVIEWED BY: _____ DATE: _____ [] UPDATED [] NO CHANGE

REVIEWED BY: _____ DATE: _____ [] UPDATED [] NO CHANGE



AGREEMENT AS TO RESOLUTION OF CONCERNS

I, _____, understand that I am entering into a contractual relationship with Jane Bucci, OD, Laryn Adams, OD, Eric Fazio, OD, Linda Huang, 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 Jane Bucci, OD, Laryn Adams, OD, Eric Fazio, OD, Linda Huang, 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 Jane Bucci, OD, Laryn Adams, OD, Eric Fazio, OD Linda Huang, MD, T. Hunter Newsom, MD /Newsom Eye & Laser Center.

Should I initiate or pursue a meritorious medical malpractice claim against Jane Bucci, OD, Laryn Adams, OD, Eric Fazio, OD, Linda Huang, MD, T. Hunter Newsom, MD, /Newsom Eye & Laser Center, 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 as Jane Bucci, OD, Laryn Adams, OD, Eric Fazio, OD, Linda Huang, MD, T. Hunter Newsom, MD, 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 Jane Bucci, OD, Laryn Adams, OD, Eric Fazio, OD, Linda Huang, MD, T. Hunter Newsom, MD 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, Jane Bucci, OD, Laryn Adams, OD, Eric Fazio, OD, Linda Huang, MD, T. Hunter Newsom, MD also agrees to exactly the same above-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)

HIPAA Notice of Privacy Practices

Newsom Eye & Laser Center, Inc.

3205 Physicians Way, Sebring, FL 33870 PH: (863) 385-1544

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1023 US Hwy 27 South, Avon Park, FL 33825 PH: (863) 452-0215

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.

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.**

LASIK SCREENING HISTORY

Patient Name: _____
(LAST) (FIRST) (MI)

Address: _____ Apt.: _____ City: _____ State: _____ Zip: _____

Phone: _____
(Home) (Work) (Cell)

Age: _____ DOB: _____ SS#: _____ Gender: M F

How did you hear about us? _____

Email _____ Have you visited our website? Yes No

Emergency Contact: _____ Relation: _____ Phone: () _____

Occupation _____ Hobbies _____

How long have you been thinking about having LASIK? _____

If you are a good candidate, how soon would you like to have the procedure? _____

When did you start wearing glasses? _____ Contact Lenses _____ DATE CLS LAST WORN _____

What problems are you experiencing with your glasses and/or contacts? _____

OCULAR HISTORY

SYSTEMIC HISTORY

- Yes No Keratoconus
- Yes No Vascularized corneas
- Yes No Loose epithelium (erosions, EBMD,etc.)
- Yes No Herpes Simplex Virus Keratitis
- Yes No Previous scleral buckle
- Yes No Dry eyes
- Yes No Exophthalmos
- Yes No Lagophthalmos
- Yes No Conjunctival edema
- Yes No Lid disease
- Yes No Flat cornea (< 41 mm)
- Yes No Steep cornea (> 46 mm)
- Yes No Uncontrolled glaucoma
- Yes No Macular Degeneration
- Yes No Cataract
- Yes No Diabetic Retinopathy
- Yes No Surgery or Injury to the Eye
Specify: _____

- Yes No Collagen/Vascular disease including:
- Yes No Lupus erythematosus
- Yes No Ankylosing spondylitis
- Yes No Cranial arteritis
- Yes No Polyarteritis nodosa
- Yes No Reiter's syndrome
- Yes No Relapsing polychondritis
- Yes No Adult rheumatoid arthritis
- Yes No Juvenile rheumatoid arthritis
- Yes No Scleroderma
- Yes No Sjogren's syndroma
- Yes No Wagener's disease
- Yes No Chrohn's disease
- Yes No Ulceractive colitis
- Yes No Imitrex (semetripam) Use
- Yes No Cordarone(Amiordarone) Use
- Yes No Accutane(Isotrentinoin)
- Yes No Pregnant or Nursing (within 6 months)
- Yes No Radiation Therapy

All of the above information is true and accurate to the best of my knowledge. I understand that this is a preliminary screening and does not constitute a true eye exam. Further examination is required to ensure that I am a candidate for Refractive Surgery.

Patient Signature: _____ Date: _____

Screeener's Signature: _____ Date: _____

Refractive Pre-Op Evaluation Scheduled: YES Appointment Date: _____ Time: _____
NO Explain: _____