P. Dee G. Stephenson, M.D., FACS

200 Palermo Place Venice, FL 34285

WELCOME TO OUR PRACTICE

We are pleased that you have chosen Stephenson Eye Associates to assist you in your eye care. Dr. Dee Stephenson has been in practice in Venice since 1989 and will do her very best to give you the excellent eye care you deserve. We think you will find our office and technical staff very pleasant and supportive of your needs.

We have enclosed a Patient Registration Form, a Medical History Form, and a Notice of Privacy Practices that we would like you to fill out and bring with you at the time of your appointment. We also ask that you please bring your Insurance Cards and a Photo ID for the office to copy. This will expedite your check-in procedure. We will be calling to remind you of your appointment the day before you are scheduled.

Please bring your eyeglasses with you for your appointment. Your eyes will be dilated for this initial examination.

Thank you again for choosing Stephenson Eye Associates. We look forward to meeting you at your appointed time.

YOUR APPOINTMENT DAY & TIME:

_____

PATIENT REGISTRATION FORM:

Please Print And Fill Out Completely

Name: Mr. Mrs. Miss Ms. _____
First Middle Last

Date of Birth:_____ Male/Female

Local Address:_____
Street City State Zip

Local Phone: Home_____Work_____Cell _____

Spouse's Name:_____Patient Email Address:_____

Out of Area Address:_____
Street City State Zip

Emergency Contact:_____Phone No.:_____

Contact Person (not living with you): _____

Relationship: _____ Phone No.: _____

Who referred you to this office: _____

Primary Care Physician: _____ Phone No.. _____

Patient's Rights of Disclosures: In general, the HIPAA privacy rule gives the individual the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means.

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical records.

_____ _____

_____ _____

Insurance Lifetime Authorization: I request that payment of my insurance benefits be made to Stephenson Eye Associates.
I authorize medical information be released to the insurance company to determine these benefits of services if necessary.

Fee Consent: I understand that not all services performed may be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I assume full responsibility for all charges.

Patient's Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

PATIENT MEDICAL HISTORY FORM:

Patient Name_____ **Date** _____

• GENERAL MEDICAL HISTORY:

Please mark if you have or had the following:

_____ High Blood Pressure
_____ High Cholesterol
_____ Arthritis
_____ Heart Trouble
_____ Stroke
_____ Migraine Heachaches
_____ Sleep Apnea
_____ Immune Deficiency Disease
_____ Tuberculosis
☐

_____ Cancer: _____
_____ Diabetes Last Blood Sugar_____ AIC _____
_____ Thyroid Disease
_____ Kidney Disease
_____ Liver Disease
_____ Hepatitis
_____ Other: _____

• MEDICATIONS/DROPS	• DOSAGE	• HOW OFTEN

Have you ever taken Flomax? _____Yes _____ No

• DRUG ALLERGIES AND REACTIONS:

_____ _____

_____ _____

YOUR EYE HISTORY: Please mark if you have any of the following

_____ Cataracts
_____ Retinal Disease
_____ Double Vision
_____ Contact Lens Wearer (Hard or Soft)
_____ Macular Degeneration
_____Glaucoma
_____ Dry Eye
_____ Any other Disorder: _____

PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS INCLUDING CATARACT SURGERY AND WHEN:

_____

_____

FAMILY HISTORY:

Has any members of your family had these diseases: (Circle all that apply) ☐Yes ☐No

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, any other disease

SOCIAL HISTORY:

Do you drink alcohol? ☐Yes ☐No If yes, how much? _____

Do you Smoke? ☐YES ☐NO If yes, how much? _____How many years? _____

NOTICE OF PRIVACY PRACTICES:

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

When signing this Privacy Notice, you are authorizing the following:

- TREATMENT

  Stephenson Eye Associates to release to any subsequent treating physician any medical information concerning diagnosis and treatment.

☐ PAYMENT

Medical records and/or information will be shared with third party payers, such as insurance companies or the Social Security Administration or its intermediaries or carriers when requested for use in connection with determining a claim for payment.

☐ APPOINTMENT REMINDERS

We may use or disclose your health information to provide you with appointment reminders, including but not limited to voicemail message, postcards, or letters.

☐ HEALTHCARE OPERATIONS

Medical record information may be used in performing the following activities:

☐ Quality improvement
☐ Reviewing competence or qualifications of healthcare professionals
☐ Underwriting, premium rating and other insurance activities
☐ Conducting or arranging for medical review, legal services and auditing functions,including fraud and abuse detection and compliance programs.
☐ Business planning and development

General administrative duties including, but not limited to:

☐ Compliance management
☐ Customer service
☐Resolution of internal grievances

☐ YOUR RIGHTS

You have the right to request restrictions regarding usage/disclosure of information
You have the right to receive confidential communications
You have the right to inspect and copy protected health information
You have the right to amend incorrect or incomplete protected health information
You have the right to receive an accounting or disclosures
You have the right to receive a paper copy of this Notice

Additional HIPAA compliance notification information is available. Please ask to speak to the Privacy Officer if you have any questions.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Date