Dr. Sam Silverblatt
1803 E 70th Street
Shreveport, LA 71105
Office: 318-798-4000
Fax: 318-798-4001

Dr. Sam Silverblatt

NEW PATIENT PAPERWORK

Full Name: _____ Birthdate: _____ / _____ / _____

Address: _____ Social Security # _____ / _____ / _____

City / State Zip _____ Home #: (_____) _____ - _____

Email Address: _____ Cell #: (_____) _____ - _____

Occupation: _____ Work #: (_____) _____ - _____

Employer: _____ Marital Status: Single /Married/Divorced/Widowed

Medical Doctor: _____ Last Medical Exam: _____ / ____ / _____

Previous Eye Dr.: _____ Last Eye Exam: _____ / _____ / _____

Who may we thank for sending you to our office: _____

Height _____ Weight _____

Do you/have you ever used Tobacco products? **Smoke or Dip** ____ Currently ____ Never ____ Previously ____ How Much

Do you drink alcohol? ____ No ____ 1 a day or less ____ 2 a day _____ 3 or more a day

Do you use illegal drugs? ____ Yes ____ No If yes, Type / Amount / How Long: _____

List any MEDICATIONS you take (Including oral contraceptives, over the counter medications, vitamins and eye drops):

Drug	Dose		Drug	Dose

Do you have any drug allergies? If yes, please list Drug with the last known reaction: ____ Yes ____ No

Drug	Reaction		Drug	Reaction

Authorization for Disclosure of Information

I authorize the disclosure of the following to the named individual's listed below.

___ Records ___ Appointment Dates ___ Account/Billing Information ___ Pick Up: Glasses/Contacts/Prescriptions

Name: _____ Name: _____

Name: _____ Name: _____

May we release your medical information to other doctors: ____ YES ____ NO
May we request your medical information from other doctors: ____ YES ____ NO
May we leave you a message on an answering machine or voice mail? ____ Yes ____ No

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This form will expire in 2020.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain Payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Signature of patient or legal representative _____ Signature of witness _____ Date _____

**** PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED ****

LIKE US and CHECK IN on FACEBOOK!

Dr. Sam Silverblatt-Vision Source & Styleyes Eyewear Boutique

NEW PATIENT HISTORY

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

PERSONAL EYE INFORMATION

Do you work on a computer? If so, how many hours a day? _____

Your reason(s) for visiting our office today: (Please check all that apply)

____ General Checkup
____ Eyes Water
____ Headaches
____ Eyes Itch
____ Light Sensitivity
____ Pain in Eyes
____ Blurred Near Vision
____ Flashes of Lights
____ Double Vision
____ Eyes Feel Tired
____ Eyes Feel Dry
____ Blurred Distance Vision
____ Night Vision Problems
____ Floating Spots in Vision
____ Blurred Intermediate Vision
____ Lost/Broken Glasses
____ Laser Vision Consultation
____ Want New Glasses
____ Want Contact Lenses
____ Want Tinted/Colored Lenses
____ Want Bifocal/Multifocal Lenses
____ Other: _____

CONTACT LENS QUESTIONAIRE:

- Are you wearing contact lenses today? ____ Yes ____ No: If yes, what type? ____ Soft ____ Rigid / Gas Permeable
- What type of solution do you use to clean and disinfect? _____
- Have you worn contacts lenses in the past? If so, please tell us why you quit _____

Please mark those activities in which you participate:

____ Tennis
____ Soccer
____ Biking
____ Gardening
____ Basketball
____ Swimming
____ Racquetball
____ Crafts
____ Skiing
____ Hunting
____ Walking
____ Jogging
____ Football
____ Fishing
____ Scuba Diving
____ Sewing
____ Dancing
____ Golf
____ Reading
____ Aerobics
____ Woodworking
____ Rollerblading
____ Baseball
____ Instruments

FAMILY HISTORY: ****Please indicate which member of your IMMEDIATE family****

Lung Disease _____
Cancer (Type) _____
Diabetes _____
Heart Disease _____
High Blood Pressure _____
High Cholesterol _____
Kidney Disease _____
Lupus _____
Strabismus _____
Blindness _____
Cataracts _____ Right _____ Left
Crossed Eyes _____
Glaucoma _____ Right _____ Left
Macular Degeneration _____
Retinal Detachment/Disease _____
Other: _____

GENERAL HEALTH

____ Weight Loss / Gain
____ Fever
____ Fatigue
____ Pregnant
____ Breast-Feeding
____ Trauma

Ocular

____ Blindness
____ Cataracts **Right or Left**
____ Glaucoma **Right or Left**
____ Macular Degeneration
____ Retinal Condition

Allergic / Immunologic

____ Lupus (SLE)
____ Rheumatoid Arthritis
____ Environmental Allergies
____ HIV Positive

Cardiovascular

____ High Blood Pressure
____ Heart Disease
____ Cholesterol
____ Vascular Disease

Endocrine

____ Diabetes
- ____ Type 1
- ____ Type 2
- ____ Year Diagnosed
- ____ Last HbA1C

____ Thyroid

Gastrointestinal

____ Crohn's Disease
____ Colitis
____ Acid Reflux / Ulcer
____ Hepatitis

Genital / Urinary

____ Urinary Tract Infection
____ Herpes
____ Chlamydia
____ Syphilis

Ears / Nose / Throat

____ Runny Nose / Post Nasal Drip
____ Sinusitis
____ Upper Respiratory Infection

Hematologic / Lymphatic

____ Anemia
____ Leukemia

Skin

____ Eczema
____ Rosacea

Muscle / Skeletal

____ Arthritis
____ Fibromyalgia
____ Ankylosing Spondylitis

Neurological

____ Multiple Sclerosis
____ Epilepsy
____ Tremors

Psychiatric

____ Anxiety
____ Depression
____ Bipolar
____ Schizophrenia

Respiratory

____ Asthma
____ Bronchitis
____ Emphysema

Surgeries: _____