

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

CONTACT LENS QUESTIONNAIRE:

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

FAMILY HISTORY:

****Please indicate which member of your IMMEDIATE family****

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

GENERAL HEALTH

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

Cardiovascular

- High Blood Pressure
- Heart Disease
- Cholesterol
- Vascular Disease

Genital / Urinary

- Urinary Tract Infection
- Herpes
- Chlamydia
- Syphilis

Muscle / Skeletal

- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis

Ocular

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

Endocrine

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

Ears / Nose / Throat

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

Neurological

- Multiple Sclerosis
- Epilepsy
- Tremors

Allergic / Immunologic

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

Gastrointestinal

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

Hematologic / Lymphatic

- Anemia
- Leukemia

Psychiatric

- Anxiety
- Depression
- Bipolar
- Schizophrenia

Skin

- Eczema
- Rosacea

Respiratory

- Asthma
- Bronchitis
- Emphysema

Surgeries: _____