Patient Acknowledgement

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgement. By signing this form, you acknowledge that you had the opportunity to review the AOS Notice of Privacy Practices describing the use and disclosure as stated in our Notice. We provide this form upon request, to comply with the Health Insurance Portability Act of 1996 (HIPPA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- AOS has a Notice of Privacy Practices and that the patient has the opportunity to review such notice.
- AOS reserves the right to change the notice at any time. A current copy may be obtained by contacting the office at 480-905-1010 or at 14275 N. 87th Street, Scottsdale, AZ 85260.

Authorization to assign Benefits

I authorize AOS and request that the payment of Medicare/insurance benefits be made directly to AOS for any and all services provided to me by AOS. If my health insurance will not allow direct payment to AOS or if AOS chooses not to accept assignment of medical benefits, I agree to immediately forward to AOS and all insurance payments I receive.

Statement of Financial Responsibility

I acknowledge that I am responsible for all charges for services provided by AOS, including any non covered services or amount not paid by insurance.

Signature: ___________________________________ Date: _____________

Parent/Guardian if under the age of 18: ___________________________________

Printed Name: ____

Your Name: ____

Email Address: ____________________________________

SS#: ____

Employer: ____

Employer Phone Number: ____________________________

Emergency Contact Information

Emergency Contact: _________________________________

Phone number: _____________________________________

If Patient Is under 18 years of age, please fill out the following:

Responsible party: __________________________________

Address: ____

City: _________________________ State: _______ Zip: _________

Phone Number: _____________________________________

Employer: ____

Employers Number: _________________________________

ARIZONA OCULOPLASTIC SPECIALIST
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION UPON PATIENT REQUEST

I, ____ , (name of patient) give my permission to disclose protected health information from my health records, including financial information, to the following people:

Name: ____

Name: ____

Patient Signature: ____ Date: __________________

OPTION

I have elected not to disclose my financial or personal health information.

Patient Signature: _____________________________________Date:___________

The HIPAA Privacy Rule gives individuals the right to request confidential communications; or that Protected Health Information is made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (please check all that apply):

- ☐ Home/Cell Telephone:
- ☐ O.K. to leave detailed information
- ☐ Leave message with call-back number only
- ☐ Work Telephone:
- ☐ O.K. to leave detailed information
- ☐ Leave message with call-back number only

Arizona OCULOPLASTIC SPECIALISTS

Medical History

Name: ______________________ Date: ______________

PCP: ______________________ Phone: ______________

Cardiologist: ______________________ Phone: ______________

Age: _____ Weight ______ Height _______ Email Address: ______________________

Are you currently taking blood thinners ☐ Yes ☐ No

Any Medication Allergies: ☐ No known allergies ☐ Yes (please list below)

Name of Medication	Type of Reaction

Medical History **(mark all that applies)**

Heart and Vascular

___ High Blood Pressure
___ High Cholesterol
___ Chest Pain
___ Murmur
___ Heart Attack: Date: ________
___ Heart Failure
___ Pacemaker
___ Other: ________________

Lungs

___ Bronchitis
___ Chronic Cough
___ Emphysema
___ Asthma
___ Wheezing
___ TB
___ Shortness of breath
___ Sleep Apnea
___ Other: ________________

Endocrine

___ Diabetes Insulin: ________
___ Thyroid Disease
___ Other: ______________

Gastro/Intestinal

___ Hiatal Hernia
___ Acid Reflux
___ Jaundice
___ Liver Disease
___ IBS
___ Other: ______________

Blood

___ Anemia
___ Hepatitis Type: _______
___ Aids/HIV
___ Bruising

Nervous System

___ Stroke
___ Head/Neck injury
___ Seizures/Epilepsy
___ Other: ______________

Arizona
OCULOPLASTIC
SPECIALISTS

Musculo-Skeletal

___ Arthritis
___ Multiple Sclerosis
___ Chronic back or neck pain
___ Other: ____________________

Genital/Urinary

___ Kidney/Renal
___ Dialysis
___ Other: ______________

Other: Cancer: Type: ________________

Surgical History: List all surgical procedures including any eye surgery

Procedure	Body Part	Date

Social History

Tobacco Use: ☐ Yes ☐ No Type: ______________ Amount: ___________ Years: _______
Alcohol Use: ☐ Yes ☐ No Type: ______________ Amount: ___________ Frequency: _______
Illicit Drug Use: ☐ Yes ☐ No Type: ______________ Amount: ___________ Frequency: _______

Family History:

___ Glaucoma: Family Member: ___ Mother ___ Father ___ Grandmother ___ Grandfather
___ Cancer Type: ______________ ___ Mother ___ Father ___ Grandmother ___ Grandfather

Medication (list all current medications , strength and dosage)

Medication	Strength	Dosage (how many times per day)

Physician review: ________________________________ Date: ________________________