PATIENT HISTORY

Name _____ Date _____

Age _____ email: _____ Have you previously seen Dr. Brown? *Yes* *No*
Last eye exam? _____ Who? _____
How did you hear about Dr. Brown? Previous Patient Doctor Referral Family Friend Insurance
TV Radio Newspaper *Name?* _____

Reason for today's exam: Annual Exam Problem Broke/lost glasses

_____

Eye problems: *Do you have or are your eyes?*

Red	Itch	Discharge	Glare	Pain	Blurry
Tearing	Burning	Floaters	Cobwebs	Flashes	Dry
Headaches	Halos	Rainbows	Foreign Body	Blind spot	Double Vision
Night blindness	Color Blindness				

Eye drops you are taking:

_____

Do you wear glasses? All the time Driving/Night/Movies Reading Never
How old are they? _____ Have you worn glasses in the past? *Yes* *No*
Do you have glasses but don't wear them? *Yes* *No* Why? _____
Do you wear contact lenses? *Yes* *No* Have you worn contacts in the past? *Yes* *No*

Are you interested in refractive laser surgery? *Yes* *No* *Don't Know*

Do you have:

Cataract	Glaucoma	Diabetes	Lazy Eye	Tumor
Retinal Detachment		Retinal Tear/Hole		Macular degeneration

Details _____

Previous Eye Surgeries: Cataract Retina Laser Right Eye Left Eye
Details _____

_____

Family Eye History: *Has any blood relative had?*
Retinal tear/detach. Blindness Glaucoma Cataracts Eye Tumor or Cancer
Other eye problem requiring treatment or causing serious visual loss: _____
Who? _____

REVIEW OF SYSTEMS

GENERAL *Have you ever had?*

- ❑ Weight loss > 10 pounds in 6 months
- ❑ Recurrent or persistent fevers, night sweats
- ❑ Persistent cough, cough up blood
- ❑ Cancer or tumors
- ❑ Serious or unusual infections
- ❑ Diabetes How many years? _____
  - ❑ On Insulin? *Yes* *No*
- ❑ Thyroid, adrenal disease
- ❑ Anemia, bleeding problems, bruise easily
- ❑ Asthma
- ❑ Jaundice
- ❑ AIDS
- ❑ Venereal disease (Syphilis, gonorrhea)
- ❑ Herpes
- ❑ Radiation treatments
- ❑ Chemotherapy

ENT *Have you ever had?*

- ❑ Hearing loss / Ringing in Ears
- ❑ Frequent nose bleeds
- ❑ Dry mouth, excessive thirst
- ❑ Difficulty swallowing
- ❑ Hoarseness or voice loss for over one month
- ❑ Sinus Problems

CVS *Have you ever had?*

- ❑ Chest pain or angina
- ❑ Collagen vascular disease (rheumatoid arthritis, Lupus, Sarcoid)
- ❑ High Blood Pressure How many years? _____
- ❑ Shortness of breath
- ❑ Heart Attack
- ❑ Heart Surgery
- ❑ Heart murmurs, defects
- ❑ Rheumatic fever
- ❑ Hardening of arteries

GI *Have you ever had?*

- ❑ Ulcers, stomach problems
- ❑ Changes in your eating habits
- ❑ Bloody or black stools
- ❑ Frequent vomiting, nausea
- ❑ Severe diarrhea, constipation
- ❑ Hepatitis

GU *Have you ever had?*

- ❑ Blood in your urine
- ❑ Pass urine more than two times at night
- ❑ Burning with urination, difficulty urinating
- ❑ Kidney disease, bladder problems

EXT *Have you ever had?*

- ❑ Swelling of your ankles or hands
- ❑ Arthritis, joint pain, stiffness
- ❑ Artificial joint
- ❑ Rheumatism
- ❑ Skin diseases, skin cancer
- ❑ Melanoma

NEUROPSYCHIATRIC *Have you ever had?*

- ❑ Dizziness, fainting spells
- ❑ Persistent headaches
- ❑ Migraines
- ❑ Seizures
- ❑ Dépression
- ❑ Psychiatric care
- ❑ Stroke
- ❑ Numbness or weakness of your arms or legs

SURGERIES Surgeon Date

_____

_____

_____

Are you or could you be pregnant or nursing? *Yes* *No*

FAMILY HISTORY *Has any blood relative had?*

Diabetes Heart disease Cancer Thyroid

Do any diseases run in your family? _____

SOCIAL HISTORY

Married Single Divorced Number of children_____

Smoke? No Packs per day _____ How many years?_____

Drink? No Socially Frequently Recreational drug use? *Yes* *No*

Occupation_____ Type of work? Office Physical/Outside Computer

Type of lighting in workplace: Outside Fluorescent Incandescent Weak Strong

PRESCRIPTION MEDICINES How often

_____

_____

_____

_____

Birth Control Pills? *Yes* *No* How long? _____

Do you take aspirin regularly? *Yes* *No* How much? _____

ALLERGIES _____

ANNUAL REVIEW

Patient's Signature_____ Date_____

Patient's Signature_____ Date_____

Patient's Signature_____ Date_____

Dilating drops used in your exam today may blur your vision and may make you light sensitive that could affect your ability to drive. Please do not drive your car unless you feel comfortable doing so. These drops could last 3-4 hours; disposable sun shields are available upon request. We do not have drops or medications to reverse the dilation.

It is our policy to collect fees from both cash paying patients and those with insurance at time of service: **including but not limited to; examination fee, special testing, co-payments, deductibles, refraction fees, optical purchases or any other purchase.** Refraction: A measurement of the lens power necessary to write and prescribe glasses or other corrective lenses. It is also used to assist with medical treatment. Most medical insurance plans (including Medicare and Medical) **DO NOT** cover routine eye exams or refractions. Medicare and most other insurance providers insist that we charge (and collect at time of service) all non-covered services. Your insurance provider should provide you with an explanation of benefits shortly after your visit, detailing your financial responsibilities.

In the event you have a separate vision plan (VSP, EyeMed, OptiumHealth, MESVision, etc.,) which covers an annual eye examination and/or glasses and contact lenses, please inform a member of our staff immediately. As a courtesy we will verify your eligibility and benefits prior to any and all treatment/exams. We will collect any and all non-covered fees (**co-payment**, **deductible and optical purchases)** at time of service. If your vision insurance is not presented on or before time of service and your full payment is collected, we will provide you with the documentation to file to your insurance provider for direct reimbursement to you. Refunds are not issued when insurance is not provided.

If you have any questions regarding Medicare, Medical and other insurance policies and procedure at Brian M. Brown, M.D., Inc., please do not hesitate to ask a member of our staff. Your signature below signifies that you understand your financial responsibility and the dilation affects.

Patient Name _____ Date_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICAIN

I hereby assign direct payment to Brian M. Brown, M.D., for any medical and/or surgical benefits allowed by my insurance carrier. I understand that any monies received by Brian M. Brown, M.D., from my insurance provider will be used to pay for my examination, testing, and surgical and/or medical treatment. Any additional monies, over and above my indebtedness will be refunded to me once my bill is paid in full. I understand that I am financially responsible for all charges not covered by my insurance or the medical authorization.

Initials _____Date _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Brian M. Brown, M.D., to release any and all information acquired during the course of any examination or treatment to third party payers for billing purposes and to process my insurance claim. I understand this is not a general medical record release form.

Initials_____Date _____

I do not authorize Brian M. Brown, M.D., to release any information acquired during the course of my examination. I agree to pay in full and at the time of each service for any and all care rendered.

Initials_____Date_____

Medicare Patients

I have not signed over my Medicare benefits to an HMO. I understand that if I do enroll with an HMO I will be responsible for all charges incurred by me for services rendered by Brian M. Brown, M.D.

Patient Name _____Date_____

MEDICARE NON-COVERED SERVICES

Certain services are not reimbursed under Medicare Guidelines. Brian M. Brown, M.D., feels I need these services and I agree to be personally and financially responsible for these services.

SERVICE	CHARGE	DATE OF SERVICE	PATIENTS INITIALS
REFRACTION	$45.00	_____	_____
_____	_____	_____	_____

Patient Name _____Date_____

Brian M. Brown, M.D.

Eye Physician & Surgeon

PRIVACY NOTICE

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 IS EFFECTIVE 02/20/2003 UNTIL FURTHER NOTICE.

Right to Notice

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Brian M. Brown, M.D. can use your protected health information for treatment, payment and health care operations.

a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
b) Payment - We may use and disclose your health information to obtain payment for services we provide you.
c) Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization
Most uses and disclosures that do not fall under treatment, payment, and health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations
In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing
We will not use your health information for marketing communications without your written authorization.

Required by Law
We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security
We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders
We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient
You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

- You have the right to receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to receive an account of disclosures of your protected health information.
- You have the right to a paper copy of this notice of privacy practices.

Legal Requirements
Brian M. Brown, M.D. is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints
If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information
For further information about Brian M. Brown, M.D.' s privacy policies, please contact Dr. Brown at the following address or phone number:
Brian M. Brown, M.D.
10933 Lakewood Blvd.
Downey, CA 90241
(562) 904-1989

Patient Acknowledgement
I herby acknowledge that I have received or have been offered to receive a copy of this notice.

_____ _____
Patient Name Date

Authorization to Allow Disclosure of Brian M. Brown MD INC Information

I, _____, authorize the following individual(s) to receive any and all information regarding my medical care. I understand that this authorization will be in effect until revoked by me in writing.

	Name	DOB	Relationship	Drivers License
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Signature of Patient: _____ Date: _____

Name of Witness: _____

_____ I grant permission for Brian M. Brown, M.D., Inc. office to leave any messages on my voicemail in the event I do not answer the phone number on record.

For office use only

Signature or ID number of BBMD INC employee that verified identity of patient: _____

Information entered into Computer System on _____ by _____

Date Initials