HIPAA AUTHORIZATION FORM

AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ hereby give my consent to **Dr. Gregory T. Komm, O.D., P.A.** to use or disclose my protected health information as described below:

PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is to carry out treatment, payment, or health care operations.

ACKNOWLEDGEMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

PERMISSION TO DISCUSS INFORMATION

I give my permission to **Dr. Gregory T. Komm, O.D., P.A.** to discuss any exam findings with the following person(s):

Name(s): _____

_____

Relationship to patient: ☐Physician ☐Spouse ☐Relative ☐Parent

Patient Signature: _____ Date:_____

If patient is under 18, parent/guardian signature:_____ Date: _____

Please print name of parent/guardian if patient is under 18 years old: _____

List currently **prescribed medications** and any vitamins/supplements you are taking:

_____

_____

List any **drug allergies** you have:

_____

EYE History:

Who was your previous eye doctor? _____

When was your last eye exam? _____

Check the box for any eye conditions that apply to you or your blood relatives:

	You	Mom	Dad	Sibling	Other relative
Glaucoma	☐	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐	☐
Retinal problems	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐
Lazy Eye/Eye turn	☐	☐	☐	☐	☐

List any major eye injuries or eye surgeries and their dates:

_____

List any other significant eye problems you have had:

_____

List all eye medications or over the counter drops you are currently using:

_____

Check any medical eye or vision complaints you are currently having, for example

☐Seeing halos at night	☐Dark spots/webs/floaters		☐Blurry vision
☐Headaches	☐Eyestrain	☐Double vision	☐Losing place when reading
☐Itching	☐Burning	☐Redness	☐Pain
☐Sensitivity to light	☐Watering	☐Crusting	☐Mucus discharge

☐Other eye problems? _____

How many hours per day do you typically spend using a computer or other digital device? _____
How many hours per day do you typically spend reading books, magazines etc.?_____

What are your hobbies/sports activities? _____
Do you have sunglasses? Yes ☐ No ☐
Do you have back-up glasses? Yes ☐ No ☐
Do you currently wear contact lenses? Yes ☐ No☐
Are you interested in contacts? Yes ☐ No ☐

Check the box for any conditions that apply to you or your relatives:

	You	Mom	Dad	Sibling
Hypertension	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Cardiovascular	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐

If YOU are diabetic, when were you diagnosed? _____

Last A1C level? _____

Women only: Are you pregnant or nursing? _____

Review of Systems: Do you have any of the following medical conditions?

If you answer yes to any of the following problems from head to toe, please specify below:

	Yes	No	Specify:
General: i.e. fever, fatigue, loss of appetite, weight loss/gain			
Ears, Nose, Throat: i.e. sinus/nasal congestion, nose bleeds, dry mouth/throat, hearing problems			
Cardiovascular: i.e. chest pain, racing heartbeat, swollen feet/ankles, stroke			
Respiratory: i.e. chronic cough, shortness of breath, wheezing			
Genital, Kidney, Bladder: i.e. bladder/urinary problems, discharge, pain, menstrual changes, impotence			
Gastrointestinal: i.e. constipation, diarrhea, gastric reflux (GERD), jaundice, nausea/vomiting			
Endocrine: i.e. heat or cold intolerance, thinning hair, excess thirst/urination			
Muscles/Bones/Joints: i.e. pain, stiffness, swelling, weakness, limited movements			
Skin: i.e. dry, itchy, flaky, rash, growths, bumps, redness, discoloration			
Neurological: i.e. headaches, numbness/tingling, tremors, poor balance, dementia			
Psychiatric: i.e. depression, anxiety, sleep problems, paranoia, obsessive/compulsive			
Blood/lymph: i.e. anemia, bleeding gums, delayed clotting, unexplained bruising			
Allergy/Immune: i.e. swollen lymph nodes, itching, sneezing, runny nose/eyes			

Do you currently smoke? Yes ☐ No ☐ Former smoker ☐

If yes, how many packs a day do you smoke? _____

Alcohol use: No ☐ Occasional ☐ 1 drink per day ☐ More than 1 drink per day ☐

Do you live alone? Yes ☐ No ☐ Assisted living ☐ Nursing home ☐

List major injuries or surgeries you have had: _____

_____

Patient Information & Medical History Form *

*Please print information as it is seen on your insurance card.

____/____/_____
Date

____ _____ _____ ____ ____ _____
Title Last First MI Suffix Nickname

____ _____ ____ _____ ____ _____
No. Street Apt. City State Zip

Cell Phone: (___)_____ Home Phone: (___)_____

Email: _____ Work Phone: (___)_____

Preferred Contact by: email ☐ Text message ☐ Call ☐

Date of Birth (mm/dd/yyyy): ____/____/_____
Sex: Female ☐ Male ☐
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐
Employment status: Employed ☐ Full time student ☐ Part time student ☐
Occupation: _____

Employer/School: _____

Parent/Guardian: _____

Who may we thank for referring you to our office? _____

Billing Information

Is the billing address the same? Yes ☐ No ☐ (If no, please enter below.)

____ _____ ____ _____ ____ _____
No. Street Apt. City State Zip

_____ (___)_____
Person responsible for the bill Phone number

Do you have Medical Insurance? ☐yes ☐no. If yes, name of plan: _____

Do you have Medicare? ☐yes ☐no. If yes, name of secondary plan_____

Do you have a separate vision plan? ☐yes ☐no.. If yes, name of plan:_____

If VSP, what are the subscriber's date of birth and last 4 digits of the SSN:_____

Primary physician's name and phone: _____

When was your last physical exam? _____