WINK OPTIQUE

Welcome to our office!

Today's Date _____

Full Name _____ Birthdate _____ Age _____ Sex: F _____ M _____
Address _____ City _____ State _____ Zip _____
Hm. Phone _____ Wk. Phone _____ Cell Phone _____
e-mail _____ Would you prefer to be contacted by e-mail? □ Yes / □ No
Employer _____Occupation _____ Soc. Sec.# _____
Are you a new patient? □ Yes / □ No Marital Status: □ Single □ Married □ Divorced □ Widowed
Date of last vision exam _____ Doctor_____
Are you pregnant at this time □ Yes / □ No
List any health problems_____
Or history of any tobacco, alcohol or substance abuse _____
Are you taking any medications? □ Yes / □ No
Please list:_____
Are you allergic to any medications? □ Yes / □ No
Please list: _____
Does anyone in your immediate family have glaucoma, cataracts, diabetes, hypertension, or any other disease? If so, what and whom?_____
Do you use cigarettes/ tobacco? _____ Alcohol? _____ Other substance? _____

DO YOU EVER EXPERIENCE THE FOLLOWING EYE HEALTH SYMPTOMS?

□ Dryness of eyes	□ Burning	□ Decreased vision	□ Headaches
□ Mucous discharge	□ Watering	□ Fluctuating vision	□ Floaters
□ Redness	□ Lights	□ Loss of vision	□ Dizziness
□ Gritty feeling	□ Eye pain	□ Tired eyes	□ Lazy eye
□ Itching	□ Infection	□ Flashes of light	□ Glare

□ Other? _____

Have you ever had any kind of eye surgery? □ Yes / □ No
If yes, please list type of surgery & date _____
Are you interested in contact lenses? □ Yes / □ No
Are you interested in eye glasses? □ Yes / □ No
Are you interested in Laser Vision Correction? □ Yes / □ No

Person responsible for Professional Fees:
Name _____ Phone _____
Address_____
City _____ State _____ Zip _____

Accounts are expected to be paid when services are rendered.

□ *Cash* □ *Check* □ *Visa* □ *Master Card* □ *American Express* □ *Discover*
□ *Vision Ins.* _____ □ *Medical Ins.* _____
□ *Medicare#* _____ □ *Medicaid#* _____ □ *DHS#* _____

We need your help in updating our marketing efforts.
Please take a moment to fill out the following preferences:

How did you learn about our office? □ *Radio* □ *Television* □ *Newspaper* □ *Magazine* □ *Mail flyer*
□ *Saw sign from street* □ *From a friend* □ *Other* _____
Whom may we thank for your referral? _____

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NOTICE OF PRIVACY PRACTICES
(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") Is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- HEALTH CARE OPERATIONS include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by present a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of February 1st, 2004 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice ore the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer:	Lori Riner		
Telephone:	918. 417.7774	Fax:	918. 417.7887
Address:	10051 S. Yale Ave., Ste. 103	Email:	winkoptiqueok@gmail.com