STEWART LASIK

LASIK

PATIENT INFO PACKET

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STEWART LASIK

Notice of Privacy Practices

1. THIS NOTICE DESCRIBES **HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED** AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. This notice briefly summarizes how we handle your health information. Upon request, we will provide further details of our privacy policies and procedures.
2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.
3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. The notice will be prominently displayed at our location and on our website. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer.
5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our privacy officer can provide you with the appropriate address upon request.

If you have any questions, please call Stewart LASIK at (713) 558.8732.

Acknowledgement of receipt of Notice of Privacy Practices:
Sign, print your name and the date to acknowledge you have read and understand the Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

I give permission for the following people to have access to my Protected Health Information:

Family members: Name(s)/Relationship _____

Friend or Caregiver: Names(s)/Relationship _____

Signature _____ Date _____

STEWART LASIK

Patient Information

Name _____ ❑ M ❑ F Date ____/____/_____

Address _____ City: _____ State: ____ Zip: _____

Home: (_____)_____-_____ Work: (_____)_____-_____ Age: _____ DOB: ____/____/_____

Social Security #_____-_____-_____ Email: _____

Emergency Contact: _____ Relationship to you: _____

Phone: (____)_____-_____

Are you: ❑ Nearsighted ❑ Farsighted ❑ Astigmatic ❑ Near w/Astigmatism ❑ Far w/Astigmatism

Do you primarily wear: ❑ Glasses or ❑ Contacts? Are your contacts ❑ Hard or ❑ Soft?

Has your prescription changed much in the past 3 years? ❑ Y ❑ N

Who is your regular Optometrist? _____ Phone #: (___)_____-_____

Have you been pregnant or nursed in the past three months? ❑ Y ❑ N

Do you have: ❑ Glaucoma ❑ Cataracts ❑ Retina Problems?

What sent you to us? (Check all that apply)

❑ Radio ❑ Paper ❑ Internet ❑ Insurance ❑ Friend ❑ Optometrist

FOR OFFICE USE ONLY

Consultation Date: ____/____/_____ @ ____:____ Procedure Date: ____/____/_____ @ ____:____

1 Day Post Op: ____/____/_____ @ ____:____ LASIK: OU OD OS

Option and Payments: PRK Custom FS200 Custom

$_____ CASH CHECK#_____ V MC D AMEX Care Credit
$_____ CASH CHECK#_____ V MC D AMEX Care Credit
$_____ CASH CHECK#_____ V MC D AMEX Care Credit

Discounts:_____

Insurance: _____

STEWART LASIK

Medical History Questionnaire

Patient Name: _____ Today's Date: ____/____/_____

Date of Birth: ____/____/_____

SOCIAL HISTORY:

Occupation: _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you use tobacco products? ❑ Y ❑ N Do you use alcohol products? ❑ Y ❑ N

PERSONAL MEDICAL HISTORY:

Are you allergic to any medication? ❑ Y ❑ N If yes, please list:

_____

List all medications that you are currently taking (prescription and over the counter):

_____

Please list any eye injuries or eye surgeries you have had and their approximate dates:

_____

DISEASE/CONDITION	Yes	No	Explain (if Yes)
Integument	❑	❑	_____
Neurologic	❑	❑	_____
Headaches	❑	❑	_____
Migraines	❑	❑	_____
Dizziness	❑	❑	_____
Ear, Nose, Throat	❑	❑	_____
Allergies	❑	❑	_____
Hay Fever	❑	❑	_____
Sinus Trouble	❑	❑	_____
Respiratory	❑	❑	_____
Asthma	❑	❑	_____
Emphysema	❑	❑	_____
Shortness of Breath	❑	❑	_____
Heart	❑	❑	_____
High Blood Pressure	❑	❑	_____
Heart Trouble	❑	❑	_____

(continued)

STEWART LASIK

Medical History Questionnaire

PERSONAL MEDICAL HISTORY: (continued)

DISEASE/CONDITION	Yes	No	Explain (if Yes)
Urinary	❑	❑	
Kidney	❑	❑	
Bladder	❑	❑	
Bone/Joint/Muscles	❑	❑	
Arthritis	❑	❑	
Lymphatic/Blood	❑	❑	
Anemia	❑	❑	
Bleeding Disorders	❑	❑	
Psychiatric	❑	❑	
Endocrine	❑	❑	
Thyroid	❑	❑	
Diabetes	❑	❑	❑ Type 1 ❑ Type 2 ❑ Controlled ❑ Uncontrolled

FAMILY MEDICAL HISTORY:

DISEASE/CONDITION	Yes	No	Relationship & Explaination (if Yes)
Blindness	❑	❑	
Glaucoma	❑	❑	
Macular Degeneration	❑	❑	
Retinal Detachment	❑	❑	
Eye Drops Every Day	❑	❑	
Arthritis	❑	❑	
Cancer (list what kind)	❑	❑	
Diabetes	❑	❑	
High Blood Pressure	❑	❑	
Kidney Disease	❑	❑	
Thyroid Disease	❑	❑	

Please list surgeries, hospitalizations, and serious illness you have had in the past 5 years:

_____

Have you ever been told you have Glaucoma, Cataracts, or Retinal problems? ❑ Y ❑ N

Do you wear glasses? ❑ Y ❑ N If "yes" what are the age of your glasses? _____

Information reviewed by W. Colby Stewart, M.D. on ____/____/_____ _____

Doctor's Signature