*Today's Date:*_____

Welcome to

Ellijay Eye Care & Ocular Wellness Center

60 Old Hwy. 5 South Ellijay, GA 30540

First Name: _____ **Middle:** _____ **Last:**_____

Home Address:_____

_____

Temporary Address if applicable:_____

Date of Birth: ____/____/_____ **Email:** _____**(For appointment reminders)**

Home Phone: _____**Cell Phone:** _____ **Work:** _____

Preferred Language: _____ **Race:** _____ **Ethnicity:** ___ **Hispanic/Latino** ___ **Not Hispanic or Latino**

Marital Status: __ **Married** __ **Single Other**__ **(Information needed for insurance purposes)**

Have you been seen in our office under a different name (ie Maiden name): _____

Primary Insurance: _____ **Plan Name:** _____

Policy Holder's Name: _____ **Policy Holder's Date of Birth:** ___/____/_____

Relationship to Policy Holder: _____ __ **ID # :** _____

Secondary Insurance: _____ **ID #:** _____

Policy Holder's Name: _____ **Policy Holder's Date of Birth:** ___/____/_____

Relationship to Policy Holder: _____ **ID #:** _____

Note: Our office will need copies of your driver's license and insurance cards (if applicable) and we may ask you to sign consent forms regarding protection of your health information (H.I.P.P.A) and to file your insurance.

Reason for Today's Visit: _____

Circle that apply

Patient Health History and Review of Symptoms

Note: There will be room for explanations if needed below.
If spaces are left blank we will take that to mean you have no problems in the following areas.

Constitutional: __Fever __Weightloss/gain __Developmental Disorders __Cancer __Other:_____

ENT: __Hearing Loss __Sinusitis __Dry Mouth __Allergies/Hay fever __Other:_____

Neuro: __Headaches /Migraines __MS __Epilepsy __Cerebral Palsy __Tumor __Stroke __Other:_____

Psych: __Depression __Attention Deficit __Anxiety Disorder __Bipolar Disorder __Other:_____

Cardiovascular: __High Blood Pressure __Stroke __Heart Disease __Vascular Disease __Other:_____

Respiratory: __Cigarette Smoker __Asthma __Bronchitis __Emphysema __Sleep Apnea __Other:_____

G. I.: __Chrons Disease __Colitis __Ulcer __Acid Reflux __Celiac Disease __Other: _____

G. U.: __Kidney Disease __Prostrate Disease/Cancer __STD (Herpes/Chlamydia as they can affect vision)
__Pregnant __Nursing __Bladder Problems __Other: _____

Muscle/Skeletal: __Rheumatoid Arthritis __Osteoarthritis __Fibromayalgia __Muscular Dystrophy
__Osteoprosis __Gout __Other:_____

Integumentary: __Eczema __Rosacea __Psoriasis __Herpes Simplex/Cold Sores __Herpes Zoster/Shingles
___Other:_____

Endo: __Diabetes Type 1 __Diabetes Type 2 __Thyroid Dysfunction __Hormone Dysfunction
__Other: _____

If you answered yes to Diabetes, please state year you were diagnosed, last A1C reading and if your sugar readings are currently stable:_____

Hem/Lymp: __Anemia __Large Volume Blood Loss __Ulcer __Other:_____

Please use this space to add any information or further explanations you feel we may need to know:

_____
_____
_____
_____
_____
_____
_____

Who is your primary care physician? _____Phone:_____ Fax:_____
When was your last medical exam?_____ Blood Work?_____

Please list all medications you are currently taking including the dosage and for which condition you are taking them. Please include any over the counter medications as well.

_____

_____

_____

_____

Are you allergic to any medications? _____ Yes _____ No If yes, please list the medication(s) below:

_____

Ocular History:

Do you take eye vitamins or Omegas? If so, what brand and how often? _____

Do you presently have or in the past ever had the following conditions? ____ Glaucoma/Glaucoma Suspect

___ Cataracts ___ Macular Degeneration (ARMD) ___ Eye Surgery (type _____) _____ Patching

___ Inflammatory Disorder _____ Strabismus (lazy or cross eye) ___ Amblyopia ___ Retinal Detachment or Hole

___ Retinal Degeneration ___ Keratoconus ___ Lasik ___PRK ___ Injury or Trauma (type _____)

___ Flashes of Light ___ Floaters ___ Chronic infections of the eye/eyelid ___ Double vision __ Prism in glasses

___ Dryness ___ Itching ___Gritty/Sand feeling ___ Excessive tearing ___ Burning

Additional comments or concerns regarding your eyes? _____

Social History:

Do you use tobacco products? ___ Yes ___ No If yes, how often and amount? _____

Have you used tobacco products in the past but not currently? ___ Yes ___ No If yes, how long since quitting?

Do you drink alcohol? ___ Yes ___ No If yes, how often and amount?_____

Family History:

Has anyone in your family (parents, siblings and grandparents) ever had any of the following conditions?

___ High Blood Pressure ___ Diabetes ___ Cancer ___ Thyroid ___ Cataract ___ Glaucoma or Suspect

___ Macular Degeneration (ARMD) ___ Amblyopia ___ Severe Myopia (nearsightedness) ___ Strabismus

___ Retinal Detachment or Disease ___ Other:_____

CONSENT FORM

Are you interested in LASIK, Bifocal Lens Implants, or other refractive procedures? Yes No

Are you interested in advanced treatment procedures for Dry eye Syndrome? Yes No

Our dilation test allows us to better evaluate the internal health of your eyes and it is highly recommended. We use drops to enlarge the pupils so we may get a better look inside your eyes. The drops will cause you to have blurred vision, affecting your near vision more than your distance and causing you to be sensitive to light for 2-3 hours. There is no extra charge for this test. Would you like this test? Yes No

Please record your signature to acknowledge your choices._____ Date:_____

TODAY YOU WILL HAVE PICTURES TAKEN OF YOUR RETINA

This is the most important part of your testing as this technology allows the doctor to better view the inside of your eye, most of the time without dilation. The doctor will be able to magnify as well as enhance the image with filters for earlier diagnosis and treatment if problems are discovered.

You will encounter a series of bright flashes, however, it's not invasive and there is no discomfort.

Note: Our office will bill your insurance for this service if applicable. Several insurance companies cover this test or require a co-pay fee, similar to what a patient would pay a dentist for x-rays.

I have read this statement and understand the importance of retinal photos and understand there may be a fee.

If you have concerns regarding this test or fees, please talk to your technician during your pre-test.

Name:_____ Date:_____

Age-Related Macular Degeneration (AMD) Risk and Symptom Assessment

AMD is the leading cause of vision loss among older Americans. It is a progressive condition that causes a part of your retina called the macula to deteriorate with age. The macula is responsible for your central vision, which allows you to do things like read, watch TV, recognize faces and drive.

Risk factors for AMD

There are several factors that may increase your risk of developing AMD, including the ones listed below. Check all that apply:

- ☐ 50 years of age or older
- ☐ Current or past smoker
- ☐ Family history of AMD
- ☐ Overweight
- ☐ Caucasian (white)
- ☐ Heart disease, high blood pressure and/or high cholesterol

Since poor night vision is a common symptom of AMD, we use the AdaptDx device to measure the number of minutes it takes you to adjust from bright light to darkness. This number is your Rod Intercept™ (RI) and it can help us detect AMD at its earliest stages. The test is non-invasive and takes 5-10 minutes to complete.

Early symptoms of AMD

Before any structural changes can be seen in the back of your eye, you may experience the following early symptoms. Check all that apply:

- ☐ Difficulty seeing in the dark
- ☐ Difficulty navigating at night
- ☐ Difficulty reading in dim light
- ☐ Other night vision problems (please specify)

Patient Name _____ Patient Signature _____ Date _____

Doctor Name _____ Doctor Signature _____ Date _____

maculogix
the AMD experts

Effective date of Notice: April 14, 2003

Notice of Privacy Practices

Dr. Melonie Clemmons and Associates
88 Highland Crossing – East Ellijay, GA 30004

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS
The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for your; testing or examining your eyes: prescribing glasses, contact lenses or eye medications and faxing them to be filled; showing you low vision aids referring you to another doctor or clinic for eye care or vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billings audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION
In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for the investigation of possible violations of health care laws
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies
- Disclosures for law enforcement purposes, such as provide information about someone who is or is suspected to be a victim or a crime ; to provide information about a crime at our office; or to report a crime that happened somewhere else
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to a id in burial; or to organizations that handle organ or tissue donations
- Uses or disclosures for health-related research
- Uses and disclosures to prevent a serous threat to health or safety
- Uses or disclosures for specialized government functions, such as for the protection of the President or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service
- Disclosures of de-identified information
- Disclosures relating to worker's compensation programs
- Disclosures of a limited data set for research, public health, or health care operations
- Incidental disclosures that are an unavoidable by –product of permitted uses or disclosures
- Disclosures to business associates who perform healthcare operations for us and who commit to respect the privacy of your health information

Unless you object, we will also share the relevant information about your care with your family or friends who are helping you with our eye care.

APPOINTMENT REMINDERS
We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OTHER USES AND DISCLOURES
We will not make any other uses or disclosures of your health information unless you sign a written authorization form. The content of an authorization form is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the authorization process if it's your idea for us to send you information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you are using one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
The law give you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information t a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost.
- Ask to see or to get photocopies of your health information. By law, there area few limited situations in which we can refuse to permit access or copying. Otherwise, you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension for the time for us to give you access or photocopies if we send you a written notice of the extension.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you write a statement of your position, and we will include it with you health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we made a permitted disclosure of your health information. By law we can have one 30-day extension of time to consider a request for amendment if we notify you of the extension.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations, disclosures with your authorization, incidental disclosures, disclosures required by law, and some other limited disclosures.
- Get additional paper copies of this Notice of Privacy Practices upon request.

All requests, including but not limited to the above mentioned, must be made in writing and sent to the office contact person at the address shown at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES
By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice Of Privacy Practices, we will post the new notice in our office and have copies available.

COMPLAINTS
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U. S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you do complain to us, send a written complaint to the office contact person at the address shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION
If you want more information about our privacy practices, visit the office contact person at the address shown at the beginning of this notice.

Please Sign the following:

I have read this Privacy Practice Notice.

Name: _____ Date: _____