

FAMILY EYE CARE  CHILDREN'S EYE CENTER
OF NEW MEXICO

303 Mulberry NE • Albuquerque, NM 87106
(505) 243-9739 phone • (505) 842-0650 fax • (800) 321-4977 toll free Familykidseye.com

Thank you for making an appointment at our office. Your appointment is with one of our specialists and you may be here for 1 to 2 hours. Sometimes the doctor may have an unexpected delay in the office or surgery. If this happens, the wait time may be longer. Most of the time, a longer wait is because the doctor needs to spend more time with a patient than expected. We will also give you or your child more time if needed. The doctor/patient relationship does not begin until the patient arrives at a first appointment and is evaluated by the physician.

You can download and print our registration and health history forms online. The doctor will need to review your completed forms before he or she sees you. If you download the forms, please complete and **bring them with you** to your appointment.

PLEASE BRING THE FOLLOWING ITEMS TO YOUR APPOINTMENT

- Current eye glasses
- **Current medical insurance card**
- Written insurance referral (this includes Tricare and some other plans)
- Payment for co-payments and/or deductibles
- List of current medicines including eye drops, vitamins, and over-the-counter medicines
- Someone to drive you home – you may have trouble driving with your eyes dilated
- Toys, snacks, books, or other items you may want while waiting (let us know if we can help you)

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If you have a medical diagnosis, we will file your medical insurance for you. If you are not sure if we are on your insurance plan, please check with them before your visit. We will collect payments for non-covered services, deductibles and/or copayments at the time of your appointment. If you need to order contact lenses, you must pay for those when we order them. If you need to make special payment arrangements, please contact us before your appointment.

The doctor will do a *refraction* as part of a complete eye examination. The refraction is the part of the eye examination when we find out if you or your child needs glasses. Most insurance companies consider refractions a routine and/or a non-covered service.

The doctor will probably need to dilate your eyes during the eye examination. This will mean you or your child will be sensitive to light and may not be able to see as clearly for a few hours. We have dark shades if needed. Although many people do not have problems driving after dilation, we suggest you have someone drive you home.

Please contact us if you have any questions before your appointment. We look forward to seeing you!

Today's Date:

Pediatric Health History

PATIENT INFORMATION			
LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
HOW WELL DOES YOUR CHILD SEE? <input type="checkbox"/> VERY WELL <input type="checkbox"/> FAIRLY WELL <input type="checkbox"/> NOT WELL <input type="checkbox"/> DON'T KNOW		HOW SMALL AN OBJECT DOES YOUR CHILD SEEM TO SEE UP CLOSE?	
DOES YOUR CHILD TURN OR TIP HER/HIS HEAD IN AN UNUSUAL WAY? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHAT CAN YOUR CHILD SEE AT FAR DISTANCES?	
CURRENT EYE PROBLEM(S)			
WHY DID YOU BRING YOUR CHILD TO THE EYE DOCTOR TODAY?		WHAT DO YOU WANT THE DOCTOR TO DO FOR YOUR CHILD?	
PLEASE COMPLETE THIS SECTION ONLY IF YOUR CHILD HAS CROSSED, DRIFTING, OR LAZY EYE(S)			
WHEN DID YOU FIRST NOTICE THE PROBLEM?		WHICH EYE HAS THE PROBLEM? <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH	
HAS YOUR CHILD EVER WORN GLASSES FOR THIS PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO		DOES YOUR CHILD WEAR GLASSES NOW FOR THIS PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAS YOUR CHILD'S EYE EVER BEEN PATCHED FOR THIS PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO		HAS YOUR CHILD EVER HAD EYE SURGERY FOR THIS PROBLEM? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CURRENT HEALTH STATUS AND HEALTH HISTORY			
BIRTH AND DEVELOPMENTAL HISTORY <input type="checkbox"/> PREMATURE <input type="checkbox"/> FULL TERM _____ POUNDS _____ OUNCES IS YOUR CHILD'S GROWTH AND DEVELOPMENT NORMAL? <input type="checkbox"/> YES <input type="checkbox"/> NO CHILD'S GRADE LEVEL: SCHOOL PERFORMANCE:		DESCRIBE ANY PROBLEMS DURING PREGNANCY, LABOR, DELIVERY, OR AFTER YOUR CHILD'S BIRTH:	
DOES YOUR CHILD WEAR GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO DOES YOUR CHILD WEAR CONTACT LENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO HAS YOUR CHILD EVER HAD AN EYE INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		ALLERGIES <input type="checkbox"/> NONE KNOWN <input type="checkbox"/> YES (PLEASE LIST BELOW)	
CURRENT HEALTH PROBLEMS <input type="checkbox"/> SEASONAL ALLERGIES <input type="checkbox"/> HEART PROBLEMS <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> CANCER <input type="checkbox"/> DIABETES <input type="checkbox"/> SEIZURES <input type="checkbox"/> LIVER PROBLEMS <input type="checkbox"/> KIDNEY DISEASE <input type="checkbox"/> LUNG PROBLEMS <input type="checkbox"/> EMOTIONAL PROBLEMS <input type="checkbox"/> CATARACTS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> DEVELOPMENT DELAY <input type="checkbox"/> MACULAR PROBLEMS <input type="checkbox"/> CEREBRAL PALSY <input type="checkbox"/> OTHER _____			
MEDICATIONS		PREVIOUS SURGERIES	
MEDICATION	DOSE AND FREQUENCY	SURGERY	YEAR

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING PROBLEMS?

GENERAL/HORMONAL	BLOOD/LYMPH NODES	SKIN/HAIR/NAILS	EARS/NOSE/THROAT	EYES	MUSCLES/BONES/JOINTS
<input type="checkbox"/> FATIGUE <input type="checkbox"/> FEVER/CHILLS <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/> HOT FLASHES <input type="checkbox"/> INTOLERANCE TO HEAT <input type="checkbox"/> INTOLERANCE TO COLD <input type="checkbox"/> WEIGHT CHANGE <input type="checkbox"/> APPETITE CHANGE <input type="checkbox"/> EXCESSIVE THIRST <input type="checkbox"/> HOARSENESS <input type="checkbox"/> VOICE CHANGES <input type="checkbox"/> NONE	<input type="checkbox"/> ANEMIA OR LOW IRON <input type="checkbox"/> ABNORMAL BLEEDING <input type="checkbox"/> SWOLLEN NODES <input type="checkbox"/> BRUISING <input type="checkbox"/> NONE	<input type="checkbox"/> COLOR CHANGES <input type="checkbox"/> CHANGE IN MOLE <input type="checkbox"/> ITCHING <input type="checkbox"/> IRRITATION <input type="checkbox"/> RASHES <input type="checkbox"/> GROWTHS <input type="checkbox"/> HAIR CHANGES <input type="checkbox"/> NAIL CHANGES <input type="checkbox"/> NONE	<input type="checkbox"/> HEADACHES <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> RINGING IN EARS <input type="checkbox"/> NOSEBLEEDS <input type="checkbox"/> RUNNY NOSE <input type="checkbox"/> SINUS PROBLEMS <input type="checkbox"/> BLEEDING GUMS <input type="checkbox"/> PAIN IN EARS <input type="checkbox"/> PAIN IN NOSE <input type="checkbox"/> PAIN IN THROAT <input type="checkbox"/> CHANGE IN TASTE <input type="checkbox"/> MOUTH SORES <input type="checkbox"/> DRY MOUTH <input type="checkbox"/> NONE	<input type="checkbox"/> VISION LOSS <input type="checkbox"/> BLURRED VISION <input type="checkbox"/> DISTORTED VISION <input type="checkbox"/> DOUBLE VISION <input type="checkbox"/> FLOATERS <input type="checkbox"/> LIGHT FLASHES <input type="checkbox"/> OTHER VISION CHANGES <input type="checkbox"/> TEARING <input type="checkbox"/> DRY EYES <input type="checkbox"/> LIGHT SENSITIVITY <input type="checkbox"/> DROOPY EYELID <input type="checkbox"/> REDNESS <input type="checkbox"/> DRAINAGE OR MUCOUS <input type="checkbox"/> ITCHING <input type="checkbox"/> PAIN OR DISCOMFORT <input type="checkbox"/> NONE	<input type="checkbox"/> JOINT PAIN <input type="checkbox"/> JOINT STIFFNESS <input type="checkbox"/> JOINT HEAT <input type="checkbox"/> MUSCLE ACHES & PAINS <input type="checkbox"/> MUSCLE STIFFNESS <input type="checkbox"/> WEAKNESS <input type="checkbox"/> CRAMPING <input type="checkbox"/> PARALYSIS <input type="checkbox"/> DIFFICULTY MOVING <input type="checkbox"/> BACK PROBLEMS <input type="checkbox"/> NONE
LUNGS	HEART	STOMACH BOWELS	KIDNEYS BLADDER/GENITALS	NEUROLOGIC	PSYCHIATRIC
<input type="checkbox"/> COUGH <input type="checkbox"/> SPUTUM PRODUCTION <input type="checkbox"/> WHEEZING <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> COUGHING UP BLOOD <input type="checkbox"/> PAIN IN LUNGS <input type="checkbox"/> NONE	<input type="checkbox"/> CHEST PAIN <input type="checkbox"/> PAIN IN ARM OR JAW <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> EXERCISE INTOLERANCE <input type="checkbox"/> EXTREMITY PAIN <input type="checkbox"/> EXTREMITY CHANGES <input type="checkbox"/> FEELING LIGHTHEADED <input type="checkbox"/> FAINTING <input type="checkbox"/> SWEATING <input type="checkbox"/> NONE	<input type="checkbox"/> BLOOD IN STOOLS <input type="checkbox"/> VOMITING BLOOD <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/> TROUBLE SWALLOWING <input type="checkbox"/> HEARTBURN <input type="checkbox"/> FOOD INTOLERANCE <input type="checkbox"/> NONE	<input type="checkbox"/> URINATING FREQUENTLY <input type="checkbox"/> PAINFUL URINATION <input type="checkbox"/> INCONTINENCE <input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> URINATING AT NIGHT <input type="checkbox"/> KIDNEY PAIN <input type="checkbox"/> GENITAL DRAINAGE <input type="checkbox"/> SORE ON GENITALS <input type="checkbox"/> NONE	<input type="checkbox"/> DIZZINESS <input type="checkbox"/> NUMBNESS <input type="checkbox"/> TINGLING OR BURNING <input type="checkbox"/> MEMORY LOSS <input type="checkbox"/> KNOCKED OUT <input type="checkbox"/> SUDDEN VISION LOSS <input type="checkbox"/> TROUBLE WALKING <input type="checkbox"/> DISORIENTATION <input type="checkbox"/> NONE	<input type="checkbox"/> DEPRESSION <input type="checkbox"/> MOOD CHANGES <input type="checkbox"/> HALLUCINATIONS <input type="checkbox"/> NIGHTMARES <input type="checkbox"/> ANXIETY <input type="checkbox"/> BEHAVIOR CHANGES <input type="checkbox"/> NONE

FAMILY AND SOCIAL HISTORY

DO OR DID ANY OF YOUR BLOOD RELATIVES (LIVING OR DEAD) HAVE ANY OF THE FOLLOWING?

<input type="checkbox"/> YES <input type="checkbox"/> NO	AMBLYOPIA	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIGH BLOOD PRESSURE
<input type="checkbox"/> YES <input type="checkbox"/> NO	PROBLEMS WITH ANESTHESIA	<input type="checkbox"/> YES <input type="checkbox"/> NO	CATARACTS IN CHILDHOOD
<input type="checkbox"/> YES <input type="checkbox"/> NO	ARTHRITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY DISEASE
<input type="checkbox"/> YES <input type="checkbox"/> NO	BLINDNESS	<input type="checkbox"/> YES <input type="checkbox"/> NO	LAZY EYE
<input type="checkbox"/> YES <input type="checkbox"/> NO	CROSSED OR WANDERING EYE	<input type="checkbox"/> YES <input type="checkbox"/> NO	LUPUS
<input type="checkbox"/> YES <input type="checkbox"/> NO	DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	NEUROLOGICAL PROBLEMS
<input type="checkbox"/> YES <input type="checkbox"/> NO	EYE CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	EARLY DEATH
<input type="checkbox"/> YES <input type="checkbox"/> NO	GLAUCOMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	RETINAL PROBLEMS
<input type="checkbox"/> YES <input type="checkbox"/> NO	GENETIC PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	STROKE
<input type="checkbox"/> YES <input type="checkbox"/> NO	HEART DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	THYROID PROBLEMS

SOCIAL ASSESSMENT

PLEASE LIST ALL SIBLINGS BELOW

NAME	AGE	HEALTH PROBLEMS (IF ANY)	NAME	AGE	HEALTH PROBLEMS (IF ANY)

WITH WHOM DOES YOUR CHILD LIVE MOST OF THE TIME?

NAME: _____ RELATIONSHIP: _____

OFFICE USE ONLY	PATIENT NOTES

REVIEWED BY: TODD GOLDBLUM, MD JOHN HICKOX, MD REBECCA LEENHEER, MD

PROVIDER SIGNATURE: _____ DATE(S): _____

Today's Date:

Pediatric Registration Form

PATIENT INFORMATION				
LAST NAME		FIRST NAME		MIDDLE INITIAL
ADDRESS		CITY	STATE	ZIP
AGE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	WHO IS YOUR CHILD'S PRIMARY CARETAKER?
WHO REFERRED YOUR CHILD TO OUR OFFICE?			WHO IS YOUR CHILD'S PRIMARY CARE PROVIDER (PCP)?	
PARENT OR LEGAL GUARDIAN INFORMATION				
LAST NAME		FIRST NAME		MIDDLE INITIAL
ADDRESS		CITY	STATE	ZIP
OCCUPATION		EMPLOYER	WORK PHONE	
HOME PHONE		CELL PHONE	E-MAIL	
THE PERSON LISTED ABOVE IS THE CHILD'S:				
<input type="checkbox"/> BIOLOGICAL PARENT <input type="checkbox"/> ADOPTIVE PARENT <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> OTHER:				
LAST NAME		FIRST NAME		MIDDLE INITIAL
ADDRESS		CITY	STATE	ZIP
OCCUPATION		EMPLOYER	WORK PHONE	
HOME PHONE		CELL PHONE	E-MAIL	
THE PERSON LISTED ABOVE IS THE CHILD'S:				
<input type="checkbox"/> BIOLOGICAL PARENT <input type="checkbox"/> ADOPTIVE PARENT <input type="checkbox"/> LEGAL GUARDIAN <input type="checkbox"/> FOSTER PARENT <input type="checkbox"/> OTHER:				
BILLING INFORMATION				
PERSON RESPONSIBLE FOR PAYMENT OF BILL			RELATIONSHIP TO PATIENT	
ADDRESS		CITY	STATE	ZIP
INSURANCE COMPANY		SUBSCRIBER	RELATIONSHIP TO PATIENT	

NAME AND SIGNATURE OF PERSON COMPLETING THIS FORM:

DATE:

FAMILY EYE CARE  CHILDREN'S EYE CENTER
OF NEW MEXICO

Notice of Privacy Practices

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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a surgery may require that your relevant protected health information be disclosed to the health plan to obtain approval for the surgery.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, training of staff, licensing, and conducting or arranging for other business activities.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: public health issues as required by law, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. We must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with these requirements.

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure for marketing purposes
- Disclosures that constitute a sale of your protected health information

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. (Please note reasonable fees may apply.) Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

If your protected health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the protected health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

We have up to 30 days to make your protected health information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information. Although we are not obligated to comply with all requests to restrict the disclosure of your protected health information, we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your personal health information for treatment purposes.

You have the right to request to receive confidential communications. We may call you with appointment reminders, cancellations, and may leave voice mail message at your home or place of employment. You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to request an amendment to your protected health information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures. You have the right to receive an accounting of all disclosures except for the following disclosures: disclosures pursuant to an authorization,

disclosures for purposes of treatment, payment, healthcare operations; disclosures required by law, that occurred prior to April 14, 2003; or disclosures six years prior to the date of this request.

You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured protected health information.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and the new terms will apply to all the information we have about you. We will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may file a complaint or report a problem to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

For More Information or to Report a Problem Please Contact Us At:

Debbie Casaus
Family Eye Care and Children's Eye Center of New Mexico
303 Mulberry Street NE
Albuquerque, NM 87106
Phone: (505) 243-9739
Fax: (505) 842-0650

If we are unable to resolve your complaint, the HIPAA regulation enables you to address your concern:

Secretary of the Department of Health and Human Services (HHS)
200 Independence Ave., SW
Washington, DC 20201

We will never retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

This Notice of Privacy Practices became effective on October 13, 2015. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature of Patient or Personal Representative

Date Signed

Name of Patient or Personal Representative (please print)

Description of Personal Representative's Authority