

PATIENT INFORMATION

Last Name		First Name		Middle Name	
Street Address			City	State	Zip
Home Phone #		Cell #		Work #	
Social Security #		Date of Birth		Male/Female	
Race		Preferred Language		Marital Status	
ETHNICITY (Circle One):		Hispanic	Non-Hispanic	Declined	

Insurance Information

Primary Insurance	Policy #	Group #	Group Name
Secondary Insurance	Policy #	Group #	Group Name

Physician Information

Primary Care Physician	Office Phone #
Referring Physician	Office Phone #

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone #
Signature	Date	

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: (Last, First, M.I.)	<input type="checkbox"/> M <input type="checkbox"/> F	DOB
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Pharmacy Name:	Phone #:
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Previous or Referring Doctor:	Date of Last Physical Exam:
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PERSONAL HEALTH HISTORY

Immunizations and Dates:	<input type="checkbox"/> Tetanus <input type="checkbox"/> Hepatitis <input type="checkbox"/> "Flu"	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Chicken Pox <input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	
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Presenting Complaint and Present Illness:

History of present Illness:

Past Medical History (Hospitalizations)

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Present Medications:
 List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers

Name of Drug	Strength	Frequency Taken

Past Medications:

Health History Questionnaire continued: Patient Name

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers previously taken:

Allergies to Medications:

Name of Drug	Reaction You Had

Surgical History:

Year	Reason	Hospital

Social History:

Smoking History: Current and Past

Do you currently use tobacco? Yes No
 Number of years you have used tobacco? _____ Packs per day? _____ If you have quit, when? _____

Caffeine: None Coffee Tea Cola # of Cups/Cans Per Day? _____

Alcohol: None Liquor/Day _____ Beer/Day _____ Wine/Day _____

Illicit Drug Use: _____

Environmental History: (exposure to toxics)

Name of Toxic	Number of years exposed

Occupation: _____ **Number of years:** _____

Marital Status: Single Married Separated Divorced Widowed

Children: Number of children _____ Any medical problems _____

History Spontaneous Abortion: No Yes

Review of Systems: Please check all that apply

Pulmonary: Cough Dyspnea Sputum Fever Chills Bloody sputum ever
 Chest tightness Wheezing Difficulty swallowing other: _____

Cardiovascular: Chest Pain Orthopnea Palpitations Arm pain Jaw pain
 other: _____

Gastrointestinal: Nausea Vomiting Diarrhea Weight Loss Weight Gain Bloody Stools
 Dark Stools Jaundice other: _____

Health History Questionnaire continued: Patient Name

Neuromuscular: Weakness Lethargy Difficulty walking Vision Problems
 Posture and balance other: _____

GYN: Females Menopause Hormonal Replacement Birth Control Pills
other: _____

Sleeping problems: Excessive daytime sleepiness Snoring Witnessed Apnea AM Headaches
other: _____

Family History:

Mother:

Father:

Siblings:

Notice of Privacy Practices

To Our Patients: This notice describes how health information (HI) about you (as a patient of this practice) may be used and disclosed, and how you can get access to your HI. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your Health Information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To the public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court and administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety of the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials where you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding Health Information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit a signed and dated request to: Zev Shulkin MD * 7777 Forest Lane Suite C-200 * Dallas, Texas 75230
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, it must be made in writing and provide us with a reason that supports your request for amendment and submitted to: Zev Shulkin MD * 7777 Forest Lane Suite C-200 * Dallas, Texas 75230
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us for a copy at any time.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice contact: Stephanie Castillo. All complaints must also be submitted in writing to the practice address. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Stephanie 972-566-3187.

Patient Name:

Signature:

Date:

CREDIT POLICY

All services rendered by the office are the patient's responsibility. We will be happy to file all insurance claims directly to your insurance company, and apply payment to your account with us at no additional charge. However, you are responsible for any amount not covered by your plan. You may be expected to pay deductible percentage amounts at the time of your visit, unless previous arrangements are made. If you are covered by a contracted company with us, you will be responsible for your copay at the time services are rendered and any additional fees the insurance lists as your responsibility after payment processing. If you do not have an insurance policy, you will be responsible for payment in full at the time of service, unless other arrangements are made previous to your visit.

I understand and agree to accept the above credit policy, and will comply with this policy:

SIGNATURE: _____ **DATE:** _____

Assignment of benefits and medical information release:

I hereby assign, transfer and set over to this physician all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with my carrier for services rendered by this physician. I authorize any holder of medical or other information about me to release any information needed to determine these benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid original.

SIGNATURE: _____ **DATE:** _____

I consent to treatment/services necessary for the care of my present condition:

SIGNATURE: _____ **DATE:** _____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Zev Shulkin and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient (or person authorized to sign for patient)

Date