

Dr. Robert H. Zoellner, P.C.
Patient Welcome/Update

For Doctor Use Only	
APPT _____	WI _____
N/P _____	P/P _____
DR _____	
VISIT CL _____	GL'S _____ OTHER _____

DATE _____

Full Name _____ Birthdate _____ Age _____ Sex _____ M _____ F _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Employer _____
Occupation _____ Soc. Sec. # _____ Referred by _____

Are you a new patient? Yes _____ No _____
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 and for what? _____

Are you allergic to any medications? _____

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?

- | | | | |
|---|------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Dryness of eyes | <input type="checkbox"/> Burning | <input type="checkbox"/> Decreased vision | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Mucous discharge | <input type="checkbox"/> Watering | <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Floaters |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Lights | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Gritty feeling | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Tired eyes | <input type="checkbox"/> Lazy eye |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Infection | <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Glare |
| <input type="checkbox"/> Other? _____ | | | |

Have you ever worn contact lenses? Hard Oxygen or gas permeable Soft Daily Wear Soft
 Extended Wear Disposables Bifocals Toric or Astigmatism design. How long? _____

Are you interested in contact lenses? _____

Person responsible for Professional Fees:

Name _____ Phone _____
Address _____
City _____ State _____ Zip _____

Accounts are expected to be paid when services are rendered.

- | | | | | | |
|---|--|-------------------------------------|--------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Cash | <input type="checkbox"/> Check | <input type="checkbox"/> Visa | <input type="checkbox"/> Master Card | <input type="checkbox"/> American Express | <input type="checkbox"/> Discover |
| <input type="checkbox"/> Vision Insurance _____ | <input type="checkbox"/> Medical Insurance _____ | | | | |
| <input type="checkbox"/> Medicare# _____ | <input type="checkbox"/> Medicaid# _____ | <input type="checkbox"/> DHS# _____ | | | |



PATIENT CONSENT FORM

Patient Name: _____ Date of Birth: _____

I, _____ consent Dr. _____ to the release of medical records for the above specified individual to:
(self, parent or guardian)

VSP
P.O. Box 997100
Sacramento, CA 95899-7100

PLEASE READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon VSP's request, to VSP for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

For additional information on VSP's Patient Confidentiality Policy, please refer to: www.vsp.com. VSP updates the Patient Confidentiality Policy periodically and reserves the rights to make changes as required.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and condition of the consent.

Signature: _____ Date: _____

VSP Doctors Only:
For more information regarding the use of the Patient Consent Form and VSP's Privacy Policy, refer to the "Policies" section of the VSP Provider Reference Manual.

PATIENT CONSENT FORM

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN BE USED TO:

*CONDUCT, PLAN, AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY OR INDIRECTLY.

*OBTAIN PAYMENT FROM THIRD-PARTY PAYERS

*CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS

I HAVE BEEN INFORMED BY YOUR OFFICE OF YOUR *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES OF MY HEALTH INFORMATION. I HAVE BEEN GIVEN THE RIGHT TO REVIEW SUCH *NOTICE OF PRIVACY PRACTICES* FROM TIME TO TIME AND KNOW THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME TO OBTAIN A CURRENT COPY OF THE *NOTICE OF PRIVACY PRACTICES*.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

IF PATIENT CANNOT SIGN OR IS A MINOR, PLEASE SIGN BELOW AND INDICATE RELATIONSHIP TO PATIENT.

PATIENT NAME: _____

YOUR NAME: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____