NEW PATIENT HISTORY FORM

Thomas B. Staskiewicz, O.D.

Please mark the correct answers and give details when appropriate.

Name _____ Social Security #: ____ - ____ - _____

1. Are you taking any medications at the present YES ☐ NO ☐
   If YES, please list:
2. Do you have ANY allergies? YES ☐ NO ☐
   If YES, please list:
3. Are you diabetic? YES ☐ NO ☐
4. Are any family members diabetic? YES ☐ NO ☐
   If YES, whom? _____
5. Who is your family doctor?
   Name: _____
   Address: _____
   _____
6. When was the last time you had a complete physical examination by a medical doctor? _____
7. Are there any eye disorders in your family, such as cataracts, glaucoma, corneal dystrophies, or retinal problems? YES ☐ NO ☐
   If YES, please explain:
8. Have you ever been told you have a crossed or lazy eye:
   YES ☐ NO ☐
   If YES, which Eye?_____
9. Have you ever been injured in the eye or had eye surgery?
   YES ☐ NO ☐
   If YES, Which eye? _____
10. Are you interested in contact lenses? YES ☐ NO ☐
11. Are you interested in refractive surgery? YES ☐ NO ☐
12. How did you hear about us? _____

WE WISH TO WELCOME YOU AS A NEW PATIENT IN OUR OFFICE

THOMAS B. STASKIEWICZ, O.D.
OPTOMETRIST
ROBINHOOD EYE CENTER
4 ROBINHOOD DRIVE
P.O. BOX 1976
CRANBERRY TWP., PA 16066
724-776-3033

NOTICE OF PRIVACY PRACTICES

The Robinhood Eye Center is required by state and federal law to protect the privacy of your medical information. This means health, treatment or payment information that identifies you.

How we use your health care information

- Provide medical treatment and optical services.
- Payments from you, insurance companies, or someone else.
- Appointment reminders, discussing treatment options.
- Notification about optical goods you ordered.

Your legal rights

- The right to have a copy of your eyeglass and contact lens prescription upon request.
- The right to have a copy of your medical records upon request.
- The right to ask that incorrect or incomplete information in your medical record be corrected.
- The right to ask for confidential communications.

If you have any questions about this notice,
please contact the doctor at 724-776-3033

SIGNATURE ON FILE :

I authorize the release of any insurance information necessary to process this or any future claims. I also request payment of vision and/or medical benefits payable to Dr. Thomas B. Staskiewicz, O.D. for services rendered.

Insurance forms are processed as a courtesy to our patients. It is the patient's responsibility to determine if and when benefits are available. We will do our best to let you know what amounts need to be paid when ordering materials, however any amounts or services not covered by your insurance company are to be paid by you. Co-payments for examinations are due when services are rendered. A $10.00 charge will be added to your account if we need to bill you for these co-payments.

All personal health information obtained for the use of electronically submitted insurance claims, facsimiles, payments, and office records will follow the guidelines as specified by the Health Insurance Portability and Accountability Act (HIPAA).

Signature:_____Date:_____

(Parent or guardian signature required for minor children)