Jorge A. Martinez, M.D. P.A.
Vision Care Center of Idaho

Rev 4/13

Date ____/____/____ Preferred Language _____

Patient Name _____ Date of Birth ____/____/____ Gender M / F

Address _____ Primary Phone (____) _____

City _____ State_____ Zip _____ Cell Phone _____

Employer _____ E-mail _____
private use only

Primary Medical Insurance _____ SSN# _____

Policy Holder Name _____ Policy Holder Birthdate ____/____/____

Emergency Contact _____ Phone (____) _____

If a minor - Mother's Name: _____ Father's Name: _____

Please contact Mom / Dad Phone (____) _____

WHO REFERRED YOU TO US? _____

PRIMARY CARE PHYSICIAN _____ **Phone Number** (____) _____

Do you have a medical power of attorney? ☐ Yes ☐ No

Who is the signator? _____ **Phone:** _____

Combined Facility/Provider Summary of Notice of Privacy:

The Federal government now requires that we notify you about how we use and disclose your health information. We are required to allow you to review our Notice of Privacy. Following is a summary of our notice. Please read it carefully.

1. We may use and disclose your medical records only for treatment, payment, or operations. Our Notice includes those parties with whom we reserve the right to exchange information. Any other uses and disclosures will be made only with your written authorization as described in our Notice of Privacy.
2. We may use your health information, as well as information from other patients to help us become more efficient and improve our quality of care. This information is for internal use only and will not be disclosed without your prior written consent.
3. We may contact you by phone, mail or e-mail to remind you of your appointments unless you notify us in writing that you do not want us to contact you. You may also restrict how we contact you. We will try to accommodate all reasonable requests.
4. We are required to disclose your health information to certain federal, state, or law enforcement agencies.
5. You may obtain copies of your records. There may be a nominal charge for these copies. You may examine your records. We may request that you make an appointment to review your records. You may request amendments to your records. We reserve the right to deny your request for amendment but will record your request.
6. We will not sell patient lists for advertising or for any other reason.
7. We are required to notify you of any changes in our privacy policies and procedures that will affect you.
8. If you believe your rights have been violated, you may file a complaint with our office or with the secretary of the Department of Health and Welfare. You will not be penalized for your complaint.
9. You have the right to discuss information in the Summary with our office manager during normal business hours. You have the right to receive a copy of the entire Notice of Privacy upon request.

I have been offered or have received a copy of the Notice of Privacy for Dr. Martinez/ VCCI, and I consent to allow my health information to be used for Treatment, Payment, and Healthcare Operations. I understand that I have certain rights as presented in the Notice of Privacy. I request that payment of insurance benefits be made on my behalf to Dr. Martinez/VCCI for any services furnished me.

I request that payment of authorized Medicare benefits be made either by me or on my behalf to Dr. Martinez/VCCI for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date: _____ Relationship (if applicable) _____

Jorge A. Martinez, M.D. P.A.

Medical History & Health Information

Patient Name _____ **Date** ___/___/___

Medical History (check all that apply)

☐ High Blood Pressure	☐ Hepatitis	☐ Stroke	☐ Retinal Detachment
☐ Heart Problems	☐ Thyroid Disease	☐ Cataract	☐ Strabismus (crossed eyes)
☐ Diabetes	☐ HIV Positive	☐ Glaucoma	☐ Eye Injury
☐ Arthritis	☐ Cancer	☐ Macular Degeneration	☐ Eye Surgery
☐ Asthma	☐ Auto Immune disease		

Medications	**Medication Allergies**
	☐ No Known Allergies

Pharmacy: _____ Location: _____

Previous Hospitalization or Surgery _____

Family History

☐ Blindness ☐ Crossed/Lazy Eye ☐ Glaucoma ☐ Cataract ☐ Retinal Detachment ☐ Macular Degeneration

Social History

Do you use...? Tobacco ☐ Yes ☐ No Alcohol ☐ Occasionally ☐ Rarely ☐ Never

Occupation: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Review of Systems

Do you currently have any of the following problems:	Yes	No	If yes, please explain
Chronic fever,unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	☐	☐	_____
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	_____
High blood pressure	☐	☐	_____
Respiratory problems (e.g., shortness of breath, wheezing)	☐	☐	_____
Hay fever	☐	☐	_____
Gastrointestinal problems (e.g., abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary problems (e.g., pain, frequency, blood in urine)	☐	☐	_____
Skin problems (e.g., rashes, excessive dryness, rosacea)	☐	☐	_____
Musculoskeletal problems (e.g., muscle aches, joint pain)	☐	☐	_____
Neurologic problems (e.g., numbness, weakness, headaches)	☐	☐	_____
Endocrine problems (e.g., diabetes, thyroid)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____

M.D. Reviewed ROS