PLEASE PRINT **Vision Associates Questionnaire** **PLEASE PRINT**

Patient Name:____ **Date of Birth:**____________________

1. **Verbal Communication**: **Please fill out your contact information and then place a check mark next to the number that you would like to be primarily used.**

_____ Home number: ___________________________________

_____ Work number: ___________________________________

_____ Cell Number: ___________________________________

May we leave detailed information on your answering machine or voice mail? YES NO

2. **Written Communication**: **Please fill out your contact information. Leave the line blank if it does not apply to you.**

Home Address: ____

E-mail Address: ____

Private Fax Number: _____________________________ Work/Office Fax Number: ______________________________

3. Additional Information:

Primary Care Physician: ___________________________________

Employer: ____

If you are a new patient how did you hear about us?

_____ Physician _____ Patient _____ Insurance Company _____ Other

_____ Hospital _____ Website _____ Staff Member

4. Meaningful Use: **The government is now asking medical practices to collect the following information.**

Language: English Spanish Arabic Chinese Japanese

German French Polish Italian Other

Ethnicity: Hispanic/Latino Not Hispanic or Latino Declined to specify

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Race: White Black/African American American Indian

Asian Pacific Islander Declined to specify

PLEASE FLIP OVER-MORE INFORMATION NEEDED ON THE BACK

5. HIPAA: HIPAA Privacy Rules give individuals the right to request a restriction on uses and disclosures of their **protected health information** (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

This form is only meant to be a quick-reference tracking tool for the physicians' office. It is not meant to replace the PHS/PPC legal forms that must be filled out by the patient, if they request any restrictions or confidential communications on their PHI.

I permit the physicians' office to discuss my PHI with, and to disclose my PHI with the following individuals:

Spouse Name:________________________________ Phone#_____________________

Adult Child(ren) Name:________________________________ Phone#_____________________

Name:________________________________ Phone#_____________________

Name:________________________________ Phone#_____________________

Family member Name:________________________________ Phone#_____________________

Friend Name:________________________________ Phone#_____________________

****If this section is left blank our office will not share your information with any family members or friends.****

Patient Signature_________________________________ **Date**________________