

# COMMERCE SQUARE OPTICAL

## ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITIES

Patient name: \_\_\_\_\_  
LAST NAME FIRST NAME M.I. DATE OF BIRTH AGE

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP CODE

E-mail Address: \_\_\_\_\_ Alternate E-mail Address: \_\_\_\_\_  
(IN THE EVENT THERE IS A NEED TO TRANSFER ELECTRONIC MEDICAL RECORDS TO A MEDICAL SPECIALIST)

Gender:  Male  Female Patient/Responsible Party's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

Employer: \_\_\_\_\_  
NAME ADDRESS CITY STATE ZIP CODE

Responsible Party: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
NAME RELATIONSHIP TELEPHONE

Emergency Contact Spouse/Next of Kin: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
NAME RELATIONSHIP TELEPHONE

Primary Care Medical Physician: \_\_\_\_\_ Referring Medical Physician: \_\_\_\_\_

Primary Medical Insurance: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_  
(EXAMPLE: BLUE CROSS BLUE SHIELD/MEDICARE/ AETNA)

Subscriber's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Medical Insurance: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_  
(EXAMPLE: MEDICARE SUPPLEMENTAL INSURANCE/ SPOUSE'S MEDICAL INSUR)

Subscriber's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Primary Vision Plan Insurance: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_  
(EXAMPLE: VISION SERVICE PLAN / SPECTERA )

Subscriber's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of one and one-half percent (1.50%) interest per month (18% per year) or the maximum allowed by law, whichever is more; to assume the cost of collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Brownwood Family Eyecare, P.A., (Commerce Square Optical dba), (CSO dba).
3. My right to payment for all procedures, tests and optometric glaucoma specialist services including major medical benefits are hereby assigned to Brownwood Family Eyecare, P.A.. This assignment covers any and all benefits under Medicare, other governmental sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Brownwood Family Eyecare, P.A.. Failure to settle any outstanding balance within ninety (90) days will result in CSO reporting patient/guarantor's to Transunion Credit Bureau.
4. I understand that I have the right to request and receive a Notice of Privacy Practices from Brownwood Family Eyecare, P.A..

**Notice to Patients:** By submitting your check for payment, you are authorizing Brownwood Family Eyecare, P.A., or its agent, upon receipt of your check to convert the check to an electronic payment item or draft and to submit it for payment as an ACH debit entry or draft to your account, in accordance with the same terms and conditions as your check.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.  
I have read and received the original of the above statements and accept the terms. A scan or copy of the above statement is considered the same as original.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
RESPONSIBLE PARTY RELATIONSHIP

PATIENT ID:  0  \_\_\_\_\_

# COMMERCE SQUARE OPTICAL

## ELECTRONIC MEDICAL RECORDS RELEASE TO/FROM PCP OR SPECIALIST

I hereby  authorize /  do not authorize **COMMERCE SQUARE OPTICAL**, its employees and agents to release and/or disclose my complete electronic medical records/history either by e-mail, telephone or mail to the following healthcare provider(s) and its physicians, employees and agents:

1. Primary Care Physician listed on Assignment of Benefits and Financial Responsibilities form.
2. Referral Medical Physician listed on Assignment of Benefits and Financial Responsibilities form.
3. Dr. Stephen P. Kelly, 100 South Park Drive, Brownwood, TX 76801.
4. Dr. Carol B. Boren, 109 South Park Drive, Brownwood, TX 76801.
5. Texas Retina Associates, 5441 Health Center Drive, Abilene, TX 79606.

I hereby  authorize /  do not authorize aforementioned healthcare provider(s) 1-5, its employees and agents to release and/or disclose my complete medical records/history either by e-mail, telephone or mail to:

### COMMERCE SQUARE OPTICAL

537 West Commerce Street  
Brownwood, TX 76801  
325-643-9336 office  
[info@DrHLIS.com](mailto:info@DrHLIS.com)

### Drug and/or alcohol, and/or psychiatric, and/or HIV/AIDS records release:

I understand that the requested information may contain reference to or results of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, and/or other sensitive information.

- I authorize the release of such confidential information to the indicated parties above.  
 I do not authorize the release of such confidential information to the indicated parties above.

### Time limit and right to revoke authorization:

This Electronic Medical Records Release authorization will remain in effect except to the extent that action has already been taken in reliance to this authorization. At any time, I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer, Stephen G. Hlis, O.D., 537 West Commerce, Brownwood, TX 76801.

### Re-disclosure:

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. Aforementioned facilities, and its employees, officers, physicians and optometric glaucoma specialist are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

### Signature of Patient or Personal Representative for EMR disclosure:

I authorize the release and/or disclosure of my complete electronic medical records/history in your possession to include history and physical, progress notes, discharge summary, consultation and operative reports, laboratory test results, x-ray reports, MRI/CT/OCT scans, photographs, diagnosis and treatment codes concerning my illness and/or treatment and/or consultation by aforementioned physicians.

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ PT ID#: 0 \_ \_ \_ \_ \_

PERSONAL REPRESENTATIVE: \_\_\_\_\_ DATE: \_\_\_\_\_ DOB: \_\_\_\_\_

# COMMERCE SQUARE OPTICAL

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Commerce Square Optical is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices. Copies are located in the office waiting room, on our website at [www.DrHLIS.com](http://www.DrHLIS.com) and on the reverse side of this form.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Commerce Square Optical.

Name: (Please Print) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### OFFICE USE ONLY:

PATIENT ID: <u>  0  </u> _____
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Name of Representative (if appropriate): \_\_\_\_\_

Signature of Representative (if appropriate) \_\_\_\_\_

Date: \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

COMMERCE SQUARE OPTICAL

STEPHEN G. HLIS, O.D.

537 WEST COMMERCE, BROWNWOOD, TX 76801

E-MAIL: [INFO@DRHLIS.COM](mailto:INFO@DRHLIS.COM)

CONTACT PERSON: STEPHEN G. HLIS, O.D.

FORM 1B

Effective Date: 27 NOV 2008

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU  
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO  
THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

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We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

#### TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

#### USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

when a state or federal law mandates that certain health information be reported for a specific purpose;

for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

uses or disclosures for health related research;

uses and disclosures to prevent a serious threat to health or safety;

uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

disclosures of de-identified information;

disclosures relating to worker's compensation programs;

disclosures of a "limited data set" for research, public health, or health care operations;

incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

#### APPOINTMENT REMINDERS

We may call, write or e-mail to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, write or e-mail to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home, and/or send it via e-mail.

#### OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

#### YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or E-Mail shown at the beginning of this Notice.

ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost incurred. If you want to ask for confidential communications, send a written request to the office contact person at the address or E-mail shown at the beginning of this Notice.

ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or E-mail shown at the beginning of this Notice.

ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or E-mail shown at the beginning of this Notice.

get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or E-mail shown at the beginning of this Notice.

get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or E-mail shown at the beginning of this Notice.

#### OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have electronic copies available upon receipt of your e-mail request, and post it on our Web site.

#### COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you wish to complain, send a written complaint to the office contact person at the address or E-mail shown at the beginning of this Notice. If you prefer, you may make an appointment with the office contact person to discuss your complaint in person or by phone.

#### FOR MORE INFORMATION

**IF YOU WANT MORE INFORMATION ABOUT OUR PRIVACY PRACTICES, SEND A WRITTEN LETTER BY MAIL OR E-MAIL TO THE OFFICE CONTACT PERSON AT THE ADDRESS OR E-MAIL ADDRESS SHOWN AT THE BEGINNING OF THIS NOTICE.**

COREL / CSO CONSENT FORMS / FORM 1B MINUSCULE 27 NOV 08

# Welcome to the office of Dr. Stephen G. Hlis

OFFICE USE ONLY:

PATIENT ID: 0 \_\_\_\_\_

DATE: \_\_\_\_\_

## New Patient History Questionnaire

Mr./Mrs./Ms./Dr. \_\_\_\_\_  
(circle one)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Type of vision insurance: \_\_\_\_\_

Name of parent or guardian if patient is a minor \_\_\_\_\_

Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary member's name: \_\_\_\_\_

Birth date of primary member: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Last Eye Exam: \_\_\_\_\_

## Medical History

Do you have any allergies to medications?  No  Yes If Yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and home remedies): \_\_\_\_\_

List all major injuries, surgeries, and/or hospitalizations you have had: \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal diseases, cataracts, eye infections, or eye injury: \_\_\_\_\_

Are you pregnant and/or nursing?  No  Yes  
Do you wear glasses?  No  Yes  
Do you wear contacts?  No  Yes  
Type of contact lenses:  Rigid  Disposables  Soft  Extended

Name of contact lense cleaning system: \_\_\_\_\_ How many hours per day do you wear them? \_\_\_\_\_

If disposable, how often do you replace them? \_\_\_\_\_

What is the main problem you are experiencing with your vision? \_\_\_\_\_

\* please complete the second page \*

## Social History

This information is kept strictly confidential. However, you may discuss this section directly with the doctor if you prefer.

Yes, I would prefer to discuss my social history information directly with my doctor.

Do you drive?  No  Yes If Yes, do you have difficulty when driving? \_\_\_\_\_

Do you use tobacco products?  No  Yes  
Do you drink alcohol?  No  Yes  
Do you use illegal drugs?  No  Yes  
Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**Family History**

Disease/Condition	Yes	No	?	Relationship to you:
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Review of Systems**

Do you currently, or have you ever had any problems in the following areas?

Systems	Yes	No	?		Yes	No	?
Constitutional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Mouth, Throat			
Fever, weight loss/gain							
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes				Respiratory			
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision/haloes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/kidney/bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles			
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic			
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any conditions not listed above: \_\_\_\_\_

**OFFICE USE ONLY:**      **PATIENT ID:**   0        **Date:** \_\_\_\_\_

**NCT: OD:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **OS:** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Time:** \_\_\_\_\_

**Blood Pressure:** \_\_\_\_\_/\_\_\_\_      **Pulse:** \_\_\_\_\_      **Time:** \_\_\_\_\_

**Print FDT, Autolensometer and HARK 599 results then transpose to ExamWriter.**