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# PATIENT INFORMATION

Welcome! Please fill out the form completely.  
We are here to make your visit a pleasant experience.

**Jessica Lattman, M.D.**  
115 East 61<sup>st</sup> Street  
New York, NY 10065  
(212) 832-5456

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LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE NAME \_\_\_\_\_

AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX \_\_\_\_\_ SOC. SEC.# \_\_\_\_\_

HOME ADDRESS STREET \_\_\_\_\_ APT.# \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME TEL # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_

EMAIL \_\_\_\_\_ FAX # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ SPOUSE/PARTNER'S NAME \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_

WHO REFERRED YOU TO DR. LATTMAN? \_\_\_\_\_ PHONE # \_\_\_\_\_

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## INSURANCE RELEASE

I request payment of authorized Medicare or other insurance carrier benefits be made on my behalf to Dr. Jessica Lattman for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Furthermore, it is my understanding that, regardless of insurance coverage, payment for services rendered is my responsibility.

I understand that if I represent my insurance incorrectly, I will be responsible for all charges pertaining to my visit(s). I understand that if a referral is required for my visit, it must be received prior to seeing Dr. Lattman. I understand if I have my eye glass prescriptions adjusted there will be a \$95.00 charge.

Payment is due in full at the time of treatment.

I have been provided with the disclosure of Protected Health Information (HIPAA) for my reading.

I am consenting to the Office of Dr. Jessica Lattman's use and disclosure of my Protected Health Information (PHI) to carry out Treatment, Payment and Healthcare Operations (TPO).

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## MEDICAL AND SURGICAL HISTORY

NAME: \_\_\_\_\_

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

<b>Do you have...?</b>	<b>Y</b>	<b>N</b>	<b>If YES, please provide details</b>
Eye disease (Dry Eye, Blepharitis)?			
Heart Disease? Heart Attack?			
High Blood Pressure?			
Do you have a pacemaker?			
Lung Disease (Asthma, Emphysema, sleep apnea)?			
Kidney Disease?			
Cancer?			
Clotting disorder (factor deficiency)?			
Easy bruising, poor healing, keloids?			
Problems with anesthesia?			
History of facial trauma?			
Depression, eating disorder, or neurological disorder?			
Skin Rashes, Skin Growths, or Cold Sores?			
Do you take Aspirin, Coumadin, Plavix, or blood thinners?			
Have you ever taken Accutane (acne medication)?			
Do you smoke?			
Do you drink alcohol?			
Do you use recreational drugs?			

**List other past and current medical and eye conditions not mentioned above:**

**List all surgeries you have had:**

**List all medications which you take on a regular basis (including vitamins and herbals):**

**List all medications which you are ALLERGIC to:**

**Do you have a *family history* of any eye or medical conditions? If yes, please provide details.**

**Please provide the name and number (if possible) of your:**

Internist: \_\_\_\_\_

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

Dermatologist: \_\_\_\_\_

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

Ophthalmologist/Optomestrist: \_\_\_\_\_

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

**PATIENT CONSENT FOR USE AND DISCLOSURE**  
**OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for The Office of Dr. Jessica Lattman to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO).

(The Office of Dr. Jessica Lattman's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Office of Dr. Jessica Lattman reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office of Dr. Jessica Lattman at 115 E. 61<sup>st</sup> Street, New York, NY 10065.

With this consent, the Office of Dr. Jessica Lattman may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, The Office of Dr. Jessica Lattman may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, The Office of Dr. Jessica Lattman may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that The Office of Dr. Jessica Lattman restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I understand that if I choose to have e-mail, confidentiality is not guaranteed.

By signing this form, I am consenting to the Office of Dr. Jessica Lattman's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it; the Office of Dr. Jessica Lattman may decline to provide treatment to me.