

Patient Information

Please **print clearly** and fill in **all** areas

LAST NAME FIRST NAME BIRTH GENDER Male Female

ADDRESS STATUS Single Married Other

CITY STATE ZIP CODE

MOBILE PHONE WORK PHONE

HOME PHONE EMAIL ADDRESS

DATE OF BIRTH SOCIAL SECURITY

EMPLOYERS NAME OCCUPATION

PRIMARY MEDICAL INSURANCE ID

SUBSCRIBER NAME DATE OF BIRTH

SECONDARY MEDICAL INSURANCE ID

SUBSCRIBER NAME DATE OF BIRTH

VISION INSURANCE ID

SUBSCRIBER NAME DATE OF BIRTH

EMERGENCY CONTACT RELATIONSHIP

EMERGENCY PHONE

Where you referred by anyone?

NAME RELATIONSHIP

I authorize release of any medical information necessary to process my claims, and payment of medical benefits to this provider for services rendered.

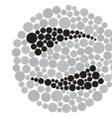
I also acknowledge and assume full financial responsibility for the health care services rendered to me if these are not covered under my insurance plan; or the services have otherwise not been approved for payment by my insurance plan; or my eligibility is not in effect as of the date of service.

I authorize Peninsula Ophthalmology Group to communicate with me using the email and phone number provided above.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

Member Signature (or legal representative)

Date



Office Policies

LATE ARRIVALS If you are more than 15 minutes late for your appointment time, we may need to reschedule your appointment in fairness to other scheduled patients and the need to have sufficient time to complete your exam.

MISSED APPOINTMENTS Missed appointments are lost opportunities for other patients. There is a \$50 charge for appointments missed without 24-hour prior notice.

CO-PAYMENTS Insurance companies require us to collect your co-payment at the time of your visit. If you wish us to bill you for this co-payment, there will be an administrative charge of \$25.00.

FEES There is a \$20.00 fee per form for completion of DMV, state disability, or miscellaneous paperwork.

RETURNED CHECKS Patients with checks returned unpaid from the bank will be charged \$50.00 per check to cover bank fees and processing.

OUTSTANDING BALANCES Account balances outstanding beyond 30 days after the date billed are subject to interest at a rate of 1½% per month. Unpaid balances past 90 days are automatically sent to an outside collection agency.

CONTACT LENSES Contact lens services may not be covered by your insurance company. Details of these fees are available on our Contact Lens Information Sheet.

Acknowledgement of Privacy Practices and HIPAA Authorization

I hereby acknowledge that I understand this medical practice’s Notice of Privacy Practices (the “Notice”). This Notice describes how we might use or disclose your protected health information, and your rights and our duties with respect to this information. You have the right to review the Notice before signing this acknowledgment. A copy of this Notice is available at the Reception Desk.

HIPAA (Health Insurance Portability and Accountability Act) allows us to release information to certain outside entities on your behalf. Otherwise by law, we are not permitted to release any medical information except to those individuals authorized by you and listed below. **I understand that Peninsula Ophthalmology Group is not responsible for the information once it is given to an authorized person.**

NAME RELATION DATE OF BIRTH

NAME RELATION DATE OF BIRTH

Relation/Date of Birth are needed so that our office can verify that we are speaking to the correct person.

I DO NOT authorize Peninsula Ophthalmology Group to release **ANY** of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Signature _____

Date _____

If not signed by the patient, please indicate relationship:

parent or guardian of minor patient

guardian or conservator of an incompetent patient



Medical History Questionnaire

LAST NAME FIRST NAME AGE TODAY'S DATE
PRIMARY CARE DOCTOR LOCATION (CITY)

PAST MEDICAL HISTORY

Allergies (List all medications that have caused an allergic reaction)

NONE

List all the medications you take (Including over the counter medications, vitamins and supplements)

NONE

List all the eye drops you take (including artificial tears and over-the-counter drops)

NONE

List all major illnesses and injuries (diabetes, hypertension, thyroid, asthma, heart disease, cholesterol)

NONE

List all past surgeries and hospitalizations in the past 3 years

NONE

If applicable, are you pregnant? NO YES MONTHS

Have you had any of these eye conditions in the past (Circle any that apply)

NONE Glaucoma Cataract Crossed Eyes Lazy Eye Eye Injury Bulging Eyes
Retinal Issues Eye Infections Droopy Eyelid Other

Do you wear glasses? NO YES: How old is your present pair of glasses?

Do you wear contacts? NO YES: What type? HARD SOFT **BRAND**

FAMILY HISTORY

Among your blood relatives, is there a history of any of the following? (Circle any that apply)

Glaucoma Lazy Eye Macular Disease Eye Surgery Unexplained Vision Loss
Cataracts Diabetes Retinal Disease Bleeding Disorder Night/Color Blindness

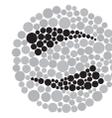
SOCIAL HISTORY

Do you use tobacco products? NO YES (How long?)

Do you drink alcohol? NO YES (Amount)

Do you use recreational drugs? NO YES (Amount)

Have you been exposed to or infected with HIV? NO YES (How long ago?)



Review of Systems

For new patients, established patients who may be having new problems, or patients we have not seen in a while, we need to update your overall medical health. In each area, circle any of the symptoms listed that you are experiencing. You may write in additional items if they are not listed. If you are not having any difficulties, please check "No problems" for each section. Thank you.

EYES

- Burning
- Chronic eyelid irritation
- Contact lens problems
- Distorted images
- Double vision
- Dryness
- Excessive tearing
- Eye pain or soreness
- Flashing lights
- Foreign body sensation
- Glare/light sensitivity
- Itching
- Loss of vision
- Mucous discharge
- Reading difficulty
- Redness

No problems

GENERAL

- Fatigue
- Fever/chills
- Weight loss/gain

No problems

SKIN

- Bruising
- Rashes
- Skin lesions
- Swelling

No problems

NEUROLOGIC

- Balance problems
- Dizziness
- Headaches
- Memory loss

No problems

EARS, NOSE, THROAT, MOUTH

- Allergies/hayfever
- Dry throat/mouth
- Hearing loss
- ringing in ears
- Sinus congestion

No problems

RESPIRATORY

- Asthma
- Cough
- Emphysema/bronchitis
- Shortness of breath

No problems

CARDIOVASCULAR

- Chest pain
- Irregular heart beat
- High blood pressure
- Leg swelling

No problems

GASTROINTESTINAL

- Diarrhea/constipation
- Reflux
- Stomach pain

No problems

GENITOURINARY

- Difficulty urination
- Painful urination

No problems

BONES, JOINTS, MUSCLES

- Back pain
- Joint stiffness/swelling
- Muscle aches

No problems

ENDOCRINE

- Diabetes
- High or low thyroid

No problems

PSYCHIATRIC

- Anxiety
- Depression
- Insomnia
- Irritability

No problems

ADDITIONAL INFORMATION

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REVIEWED BY DATE

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