PENINSULA
OPHTHALMOLOGY GROUP

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 _____

For Office Use ..... Entered By ..... POG 1-2021

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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

PENINSULA
OPHTHALMOLOGY GROUP

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?) .....

[PLEASE TURN OVER FOR QUESTIONS ON BACK OF SHEET]

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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** .....

REVIEWED BY ..... **DATE** .....