SAN DIEGO EYE CLINIC

Date:

Patient Registration and Health History

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Female ☐ Male

First Name: _____ Last Name: _____ Age: _____ Birth Date: _____

Parent's Name (If patient is a minor): _____ If a student. Grade: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone_____ Type: ☐ Cell ☐ Home Work Phone_____

Emergency Contact Phone: _____ E-mail Address_____

Occupation_____ Have you had your eye exam at this office before? ☐ Yes ☐ No

What is the reason for seeking vision care at this time?_____

_____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent Insured's Date of Birth_____

Insured's Name_____ Insured's Employer: _____

Insured's ID: _____ Insurance Plan Name: _____ Auth. No: _____

☐ Please check this box if there have been no changes to your medical and ocular history since your last visit at this office

PATIENT'S VISUAL SYMPTOMS
✓ *(Check each you have had)*

- ☐ None, routine eye exam
- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Burning eyes
- ☐ Discomfort at NEAR tasks (e.g., reading, sewing)
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye strain
- ☐ Headaches related to eyes
- ☐ Itching eyes
- ☐ Light sensitivity
- ☐ Red eyes
- ☐ See flashing lights
- ☐ See floaters or spots
- ☐ Temporary loss of vision
- ☐ Twitching eyelids
- ☐ Variable vision
- ☐ Watery eyes
- ☐ Other.

PATIENT'S HEALTH HISTORY
✓ *(Check each you have had)*

- ☐ None
- ☐ Allergies
- ☐ Asthma
- ☐ Blackouts
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Drug sensitivity
- ☐ Glaucoma
- ☐ Other
- ☐ Hay fever
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Lazy eye (Amblyopia)
- ☐ Migraine headaches
- ☐ Macular Degeneration
- ☐ Poor color vision
- ☐ Skin conditions
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Turned eye

FAMILY HEALTH HISTORY
✓ *(Check each ilsomeole in your family has had)*

- ☐ None
- ☐ Allergies
- ☐ Asthma
- ☐ Blackouts
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Drug sensitivity
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Lazy eye (Amblyopia)
- ☐ Migraine headaches
- ☐ Macular Degeneration
- ☐ Poor color vision
- ☐ Skin conditions
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Turned eye
- ☐ Other

When was your last eye exam: _____ What is your previous eye doctor's name? _____

Have you had any serious eye disease, eye injury, or eye surgery? ☐ Yes ☐ No

If yes, please explain: _____

Do you wear contact lenses? ☐ Yes ☐ No

If yes, which type? ☐ Hard ☐ Soft ☐ Disposable

When was your last visit to your medical physician? What is your medical physician's name?

For Women: Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Do you smoke, consume alcohol, or use recreational drugs? ☐ Yes ☐ No

If yes, please explain: _____

Are you presently taking any medication or drugs? ☐ Yes ☐ No

If yes, what drugs are you taking? _____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, which? _____

Signature: _____ Date: _____

☐ **Declining Dilation?**

I have been informed of the need for a dilated examination of my eyes. It has been explained to me and I understand that a condition with the potential for partial or total loss of vision may exist and without dilation it may go undetected. Being advised of the above, I hereby decline to have my eyes dilated.

OD Signature: _____ Patient Signature: _____ Date: _____

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- ✓ A statement that this practice is required by law to maintain the privacy of protected health information.
- ✓ A statement that this practice is required to abide by the terms of the notice currently in effect.
- ✓ Types of uses and disclosures that this practice is permitted to make for each of the following purposes:
  Treatment, payment and health care operations
- ✓ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- ✓ A description of uses and disclosures that are prohibited or materially limited by law.
- ✓ A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- ✓ My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient hereby consents to telephonic and text communication of health-related information with San Diego Eye Clinic.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Payment Policy

I hereby assign all medical benefits, to include all major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to San Diego Eye Clinic. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed San Diego Eye Clinic within 60 days, I may be billed for any services or products that I have received. I certify that my responses on this form are accurate to the best of my knowledge. I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs. If I am a member under Medicare/MediCal, and if I elect to receive products or services that are not covered benefits, I accept sole responsibility for payment for such products or services.

Signature: _____ Date: _____