PATIENT MEDICAL HISTORY INFORMATION FORM

Patient Name: _______________________________ Date: ____________

Please check appropriate box if you have history of:

☐ Diabetes
☐ High Blood Pressure
☐ Heart Disease
☐ Thyroid Disease
☐ Abnormal Bleeding
☐ Cancer
☐ High Cholesterol
☐ Stroke
☐ Asthma
☐ Allergies
☐ Prematurity at birth
☐ Other Eye Problems: __________________________________________

☐ Emphysema
☐ Migraine Headaches
☐ Smoking
☐ Macular Degeneration
☐ Cataracts
☐ Glaucoma
☐ Retinal Detachment
☐ High Myopia
☐ Lazy Eye, Stabismus/Amblyopia
☐ Eye Surgery

In case of emergency, please call: ________________________________

Phone Number: ________________ Relationship to Patient: ______________

Family Eye Problems:

☐ Glaucoma
☐ Retinal Detachment
☐ Macular Degeneration
☐ Retinitis Pigmentosa
☐ High Myopia
☐ Other: __________________________________________

Are you allergic to any medication?  ☐ Yes  ☐ No

If yes, what medications: __________________________________________

Please list all current medications: __________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________
<table>
<thead>
<tr>
<th><strong>Retinal Diagnostic Center</strong></th>
<th><strong>Patient Information (PLEASE PRINT)</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Circle One: Male / Female</strong></td>
<td><strong>Date____________________</strong></td>
</tr>
<tr>
<td><strong>Last Name</strong></td>
<td><strong>First Name</strong></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td><strong>Home Phone #:________________</strong></td>
</tr>
<tr>
<td><strong>City:</strong></td>
<td><strong>State/ Zip Code:</strong></td>
</tr>
<tr>
<td><strong>Age:</strong></td>
<td><strong>Date of Birth:</strong></td>
</tr>
<tr>
<td><strong>Email Address:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employer’s Name:</strong></td>
<td><strong>Occupation:</strong></td>
</tr>
<tr>
<td><strong>Employer’s Address:</strong></td>
<td><strong>Phone #:________________</strong></td>
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<tr>
<td><strong>Name of Responsible Party:</strong></td>
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</tr>
<tr>
<td><strong>Spouse’s Name:</strong> Mr. / Mrs.</td>
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<tr>
<td><strong>Spouse’s Employer’s Name:</strong></td>
<td><strong>Occupation:</strong></td>
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<tr>
<td><strong>Referring Physician:</strong></td>
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<td><strong>Family Physician:</strong></td>
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<tr>
<td><strong>Primary Insurance:</strong></td>
<td><strong>Subscriber:</strong></td>
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<tr>
<td><strong>Secondary Insurance:</strong></td>
<td><strong>Subscriber:</strong></td>
</tr>
<tr>
<td><strong>Relationship to Patient:</strong></td>
<td><strong>Date of Birth:</strong></td>
</tr>
<tr>
<td><strong>Group #:________________</strong></td>
<td><strong>I.D. #:________________</strong></td>
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</table>
State of California Patient Questionnaire

The California Health and Safety Code (Section 128737) requires that we collect the following information for the Office of Statewide Health Planning and Development. In compliance with this code, we ask that you please complete the following questionnaire.

Patient Name: ________________________________ Date: __________________

Gender: □ Male □ Female

Language: __________________________________________

Marital Status: ______________________________________

(Please circle One)

Ethnicity: African American - American Indian/Alaskan Native - Asian - Asian Indian - British -

Cambodian - Caucasian - Central American - Filipino - French - Hispanic or Latino - Korean - Pacific

Islander - Non Hispanic or Non Latino - Other: ________________________________

Decline to State

Race: African American - American Indian/Alaskan Native - Caucasian - Hispanic Latino - Hawaiian or

Other Pacific Islander - Unknown - Other: ________________________________

Decline to State
TO OUR PATIENTS:

As consultants, working along with your other physicians in the diagnosis and treatment of retinal diseases, we must from time to time order testing which we believe is essential for the diagnosis, understanding, and management of your eye condition. No testing is performed without clear clinical indications, and every effort is made to keep the cost of your treatment as low as possible.

We will bill your insurance for all services. Payment from your insurance is subject to your deductible.

Insurance regulations allow certain tests to be arbitrarily labeled as “not reasonable and necessary for the treatment of the illness or injury.” On the basis of this, any test may be singled out by your insurance to be denied reimbursement.

We deeply regret such cost saving measures; however, we can only practice in a way which will provide excellence to you, which we believe you deserve. If this discriminatory action occurs in our request for reimbursement, we will be forced to collect the cost of these services directly from you, but WILL appeal the case for you to the insurance authorities.

If we are NOT in your insurance network, your services will fall under “OUT OF NETWORK” which may result in high deductibles and higher share of cost to the patient.

ALSO:

ALL COPAYS ARE DUE AT THE TIME OF SERVICE.

A $15.00 SERVICE FEE WILL BE BILLED TO YOU IF WE CANNOT COLLECT AT THE TIME OF SERVICE.

PATIENT AGREEMENT:

SIGNATURE: __________________________ DATE: ____________
AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the HIPAA Compliance Privacy Laws of the Federal Government, it is mandatory that we ask you to review and answer the following questions listed below.

Name: ________________________________

May we leave messages/detailed medical information on voicemail at either of these phone numbers? □ Yes □ No

Home Phone: ____________________________

Cell Phone: ____________________________

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _________________________ Extension: ________________

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)? □ Yes □ No
If yes, please provide:

Name: ________________________________ Relationship: _____________________

Phone Number: _________________________ Alternate Number: __________________

Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: ________________________________ Relationship: _____________________

Phone Number: _________________________ Alternate Number: __________________

I hereby authorize ___________ Retinal Diagnostic Center ___________ to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed _________________ Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: __________________________ Date: _________________________

WITNESSED BY: ___________________________