Retinal Diagnostic Center

□ 3395 S. Bascom Ave, Ste. 140 Campbell, CA 95008 Ph. (408) 559-0666 Fax (408) 377-0811
□ 200 Jose Figueres Ave, Ste. 240 San Jose, CA 95116 Ph. (408) 937-0928 Fax (408) 254-8954
□ 1663 Dominican Way, Ste. 110-A Santa Cruz, CA 95065 Ph. (831) 476-5888 Fax (831) 476-5563
□ 65 Nielson St., Ste. 115 Watsonville, CA 95076 Ph. (831) 724-2626 Fax (831) 724-2676
□ 123 DiSalvo Avenue, Ste. E, San Jose, CA 95128 Ph. (408) 418-2200 Fax (408) 418-2205
□ 8833 Monterey Road, Suite D, Gilroy, CA 95020 Ph. (669) 500-4955 Fax (669) 500-4956
□ 3301 El Camino Real, Suite 101 Atherton, CA 94027 Ph. (650) 257-3861 Fax (650) 562-7843

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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
- □ Emphysema
- □ Migraine Headaches
- □ Smoking
- □ Macular Degeneration
- □ Cataracts
- □ Glaucoma
- □ Retinal Detachment
- □ High Myopia
- □ Lazy Eye, Stabismus/Amblyopia
- □ Eye Surgery
- □ Other Eye Problems: _____
  _____

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: _____

_____

_____

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Patient Information (PLEASE PRINT)

Circle One: Male / Female Date_____

Last Name_____**First Name**_____Social Security #:_____

Address: _____ Home Phone #:_____

City: _____ State/ Zip Code: _____ Cell Phone #: _____

Age: _____ Date of Birth: _____ Marital Status: Single____ Married____ Other_____

Email Address:_____

Employer's Name: _____ Occupation: _____

Employer's Address: _____ Phone #: _____

Name of Responsible Party: (if necessary) _____

Address: _____ Home Phone #:_____

City: _____ State/ Zip Code: _____ Cell Phone #: _____

Spouse's Name: Mr. / Mrs. _____

Spouse's Employer's Name: _____ Occupation: _____

Address: _____ Home Phone #:_____

City: _____ State/ Zip Code: _____ Cell Phone #: _____

Referring Physician: _____

Address: _____ Phone #:_____

City: _____ State/ Zip Code: _____ Fax #: _____

Family Physician: _____

Address: _____ Phone #:_____

City: _____ State/ Zip Code: _____ Fax #: _____

Primary Insurance: _____ Subscriber: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security #: _____

Group #: _____ I.D. # _____

Secondary Insurance: _____ Subscriber: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security #: _____

Group #: _____ I.D. # _____

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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

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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 COLLEC AT THE TIME OF SERVICE.

PATIENT AGGREEMENT:

SIGNATURE: _____ DATE: _____

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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: _____

□ Yes □ No 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: _____