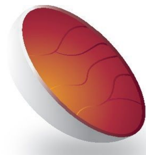


Patient History

Name: ________________________________ Date of Birth: __________________

MEDICATIONS- List all medications you are currently taking.
See attached list:☐
Name of Medication: Dosage: Reason Prescribed:

____
____
____
____

Over-the-counter medications/vitamins:

____
____

ALLERGIES: Do you have any allergies to medications? YES☐ NO☐
If so, list medication and type of reaction:

____
____
____

Do you have any of the following illnesses? And if so, the year diagnosed.

			YEAR				YEAR
Diabetes	YES	NO		Hypertension	YES	NO	
Macular Degeneration	YES	NO		Glaucoma	YES	NO	
Cancer	YES	NO		Stroke	YES	NO	
Lupus	YES	NO		Arthritis	YES	NO	
Heart Disease	YES	NO		Lung Disease	YES	NO	
Kidney Disease	YES	NO		Hepatitis	YES	NO	
Multiple Sclerosis	YES	NO		HIV Positive	YES	NO	
Tuberculosis	YES	NO					

List any other major illnesses and diagnosis years:

____
____

SURGERIES:
List any surgeries (including eye surgery) or operations you have had and the year they occurred.

____

____

EYE PROBLEMS:

Blurred Vision	YES	NO	Blind Spots	YES	NO
Floaters	YES	NO	Flashing Lights	YES	NO
Distortion of Vision	YES	NO	Fluctuating Vision	YES	NO
Double Vision	YES	NO	Loss of peripheral vision	YES	NO
Light Sensitivity	YES	NO	Poor Night Vision	YES	NO
Tunnel Vision	YES	NO			

FAMILY HISTORY:
These questions refer to your grandparents, parents, aunt, uncles, brothers and sisters, children or grandchildren.
Has anyone in the **family** had/has:

Glaucoma	YES	NO	Diabetes	YES	NO
Blindness/Poor Vision	YES	NO	Cancer	YES	NO
Heart Disease	YES	NO	Stroke	YES	NO
Hypertension	YES	NO	Cataracts	YES	NO

SOCIAL HISTORY:
What is your present weight? ____________
What is your present height? ____________
What is your current occupation? ____________
Are you married? ____________
Do you have any children? ____________

Do you drive?	YES	NO
Is driving a necessity for you?	YES	NO
Do you drink alcohol?	YES	NO
Do you smoke?	YES	NO
Have you ever smoked? Year quit:	YES	NO
Have you ever used intravenous (street) drugs?	YES	NO

SYMPTOMS (Page 1 of 2): Check any of the following symptoms you are currently experiencing.

HEAD AND NECK

Congestion	YES	NO	Hearing Problems	YES	NO
Sores or lesions in mouth	YES	NO	Lumps or nodes in neck	YES	NO

HEART

Chest Pain	YES	NO	Palpitations	YES	NO
Edema	YES	NO	Fainting	YES	NO

LUNGS

Shortness of Breath	YES	NO	Cough	YES	NO
Sputum Production	YES	NO	Wheezes	YES	NO
Coughing Blood	YES	NO			

GASTROINTESTINAL

Abdominal Pain	YES	NO	Diarrhea	YES	NO
Blood or Pus in Stool	YES	NO			

GENITOURINARY

Painful Urination	YES	NO	Blood in Urine	YES	NO
Frequency	YES	NO	Urgency	YES	NO
Genital Lesions	YES	NO			

NEUROLOGICAL

Focal Neurologic Deficit	YES	NO	Weakness	YES	NO
Tingling in Arms and Legs	YES	NO	Incoordination or Headaches	YES	NO

MUSCULOSKELETAL

Joint Pain	YES	NO	Back Pain	YES	NO
Swelling	YES	NO	Stiffness	YES	NO

SYMPTOMS (Page 2 of 2): Check any of the following symptoms you are currently experiencing.

PSYCHOLOGICAL

Depression or Anxiety	YES	NO	Forgetfulness	YES	NO

HEMATOLOGICAL

Bleeding Problems	YES	NO	Swollen Glands	YES	NO

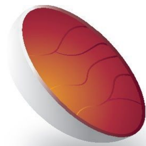
SKIN

Rashes	YES	NO	Redness	YES	NO

OTHER

Unexplained Weight Loss	YES	NO	Night Sweats	YES	NO

Signature: ______________________________ **Date:** ______________



Patient Name: ________________________________ **Today's Date:**___________________

Do you reside in a care facility? YES☐ NO☐

Name of preferred pharmacy: ____

Pharmacy Address, cross streets or city, & phone number:

____

Please complete the following:

Primary Care Physician:____

General Opthamologist (eye doctor): ____

Optometrist (glasses):____

Other physicians:____

Language Preference:

- ☐English
- ☐Spanish
- ☐French
- ☐Japanese
- ☐Other:_______________

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hipsanic/Latino
- ☐ Middle Eastern
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Causcasian
- ☐ Other: _______________

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone: ______________________
- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ Mail to my home
- ☐ Mail to my work
- ☐ Fax when requested
  Fax Number: _______________

☐ Work Telephone:________________________

☐ Other: _________________________________

Print Name	Signature	Date

The privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosures of, and request for PHI to the minimum necessary to accomplish intended purpose. These provisions do not apply to uses or disclosures made to pursuant to an authorized request to the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO (Treatment Payment Options) may be permitted without prior consent in an emergency.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ______________________ understand that as part of my health care, Retina Consultants of Southern California originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A mean by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Retina Consultants of Southern California is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this cosnet or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations. Should Retina Consultants of Southern California change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

☐ **I fully understand and accept the terms of this consent.**

Patient's Signature: ____ **Date:**_______________

Authorization to Release Information

In accordance with the Patient Privacy Act, we must obtain your written permission to release medical information. If you wish to authorize that your medical information be shared with specific individuals, i.e. spouse, children, caregiver, please sign and complete the section below. We may not discuss your care or any information if we do have a signed release on file. Thank you.

Authorization to release information:

I hereby give authorization to Retina Consultants of Southern California to speak with the following individual(s) regarding my medical care and treatment:

Individuals Name:	Relationship:	Contact Number:

PATIENT'S NAME	**SIGNATURE**	**DATE**

Retina Consultants of Southern California
Financial Policy ("RCSC") page 1 of 2

We are committed to providing you with the highest level of service and quality care. Our office strives to help you receive the maximum allowable benefits of your medical insurance. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide Medical and Surgical retinal care to our patients, as opposed to routine eye exams. If you have a managed care plan (HMO) a referral is required for every visit in order for services to be covered under your plan. If a referral has not been received, you will have the option to reschedule your appointment or pay for your treatment privately at the time services are rendered.

If there is any change in your insurance coverage and we are not notified prior to your visit then you will be responsible for all incurred fees. This includes changes in your HMO Managed Care Plan or Medical Group.

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Make sure a copy of your current insurance card is on file.
- Notify our office of any changes including insurance changes, address, phone numbers and employer.
- Be aware our office policy is that copays are due at time of service and will not be billed. We accept cash, checks, Visa, Discover, Master Crad, American Express and Care Credit.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay the balance in full, please notify our billing department immediately to discuss payment plan options. All returned checks will result in a $35 fee, which will be added to your account and must be paid before the next visit. Any balance remaining on your account 90 days past due will automatically incur a 25% increase on the balance outstanding if being forwarded to a collection agency.

I understand if I have an unpaid balance to RCSC and do not make satisfactory payment arrangements or fail to make payments as arranged, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

____________________	____________________	____________
PRINT NAME	**SIGNATURE**	**DATE**

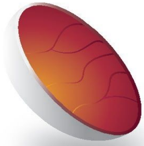
Retina Consultants of Southern California
Financial Policy (“RCSC”)

In order for RCSC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that RCSC and the designated external collection agency are authorized to (i) contact me by telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me but sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment/ In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

I have read and understand the above financial policy.

______________________	______________________	______________
PRINT NAME	**SIGNATURE**	**DATE**



Retina Consultants
of SOUTHERN CALIFORNIA

Medical and Surgical Diseases of the Retina and Vitreous

John P. Carlson, MD
Richard D. Pesavento, MD
Eric K. Chin, MD

Dear Patient:

We have a patient portal available online. If you would like to have the ability to review and print the summary of your visit please leave your email below and we will send you an invitation to set up your online account.

Patient Name:____

Email Address:____

Patient Profile

Doctor: ______________________

PATIENT INFORMATION

Name:____________________________

Address: ________________________

____

City,State: _____________________

Phone:______________ □Home □Work □Other

Phone:______________ □Home □Work □Other

Patient ID #:_________________ Sex: □M □ F

Date of Birth: ______________________________

Social Security Number: _____________________

Marital Status: □Married □Single □Divorced

Referring Physician: _________________________

Primary Physician: __________________________

PATIENT EMPLOYMENT

□Employed □Retired □Unemployed □Other

Phone: ______________________________

Employer:____________________________

EMERGENCY CONTACTS

Name: ___________________________________

Number: _________________________________

Relationship: ______________________________

GUARANTOR

□ Same as Patient

Name: __________________________________

Address:________________________________

____

City, State:______________________________

EMPLOYMENT

Employer:________________________________

Phone:__________________________________

Phone:__________________________________

Social Security #:__________________________

Date of Birth:

PRIMARY INSURANCE □Same as Patient □Same as Guarantor □Other

Insured Party:___________________________

Insured Phone: __________________________

Company:_______________________________

Relationship to Patient: ______________________

Social Security #:___________________________

Insured ID:________________________________

Policy Group: ______________________________

Date of Birth: _______________________________

SECONDARY INSURANCE □Same as Patient □Same as Guarantor □Other

Insured Party:___________________________

Insured Phone: __________________________

Company:_______________________________

Relationship to Patient: ______________________

Social Security #:___________________________

Insured ID:________________________________

Policy Group: ______________________________

Date of Birth: _______________________________

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
2. In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by Medicare.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits of the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (patient or parent of minor):_________________________________ **Date**: ___________________