eye STUDIO

Tel: (619) 521 - 2020 • Fax: (619) 521 - 2025

PATIENT REGISTRATION FORM (PRINT CLEARLY)

PATIENT NAME____ TODAY'S DATE _____/_____/_____

DATE OF BIRTH_____/_____/_____ AGE__________ SSN # _______-_______-_______ SEX: ☐ M ☐ F

STATUS: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed CELL PH# ( ) ______________

ADDRESS____ HOME PH# ( ) ______________

CITY____________________ STATE __________ ZIP__________ E-MAIL ______________________

EMPLOYER____ WORK PH # ( ) ______________

OCCUPATION______________________________ DO YOU WORK ON A COMPUTER? YES/ NO. _______HRS PER DAY

EMERGENCY CONTACT ______________________________ PHONE (______) ______________

DATE OF LAST MEDICAL EXAM______________ NAME OF MEDICAL DR.______________ PHONE______________

DATE OF LAST EYE EXAM______________ NAME OF LAST EYE DR.______________ PHONE______________

PURPOSE OF TODAY'S VISIT ____

HOBBIES / SPORTS / SPECIAL VISUAL DEMANDS____

DO YOU WEAR GLASSES? YES / NO IF YES, FOR DISTANCE / COMPUTER / NEAR HOW OLD ARE THEY? ______

DO YOU WEAR CONTACT LENSES? YES / NO IF NO, ARE YOU INTERESTED IN ( ) FULL TIME WEAR ( ) OCCASIONAL WEAR

ARE YOU INTERESTED IN CONTACT LENSES THAT CORRECT YOUR VISION WHILE YOU SLEEP? YES / NO

HAVE YOU HAD REFRACTIVE SURGERY/LASIK? YES / NO IF NO, ARE YOU INTERESTED IN THE PROCEDURE? YES / NO

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

*****PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED*****

A Fifty Percent (50%) deposit on all contact lenses and glasses is required before order can be placed. The balance must be paid before materials are dispensed. **We accept Visa, MasterCard and Debit Cards.**

Vision (please circle)

Vision Service Plan (VSP) Medi-Cal Healthy Families Blue Vision Aetna United Health Care DavisVision Molina

EyeMed Advantica Eye Care Tricare Other:______________________

Medical (please circle)

HMO (referral needed)______________________ PPO (no referral needed) ______________________

I AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PRACTITIONERS.

I UNDERSTAND THAT NOT ALL 'COVERED SERVICES' WILL BE PAID BY INSURER. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE, WORKERS' COMPENSATION, OR THIRD PARTY PAYER.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY AND/OR GOVERNMENT BENEFITS TO PAY DIRECTLY TO THE DOCTORS.

I HEREBY GIVE MY PERMISSION TO EYE STUDIO OPTOMETRY, INC. TO ADMINISTER AND TREAT WITH SUCH PROCEDURES AS MAY BE DEEMED NECESSARY IN THE DIAGNOSIS AND/OR TREATMENT OF MY EYE CONDITION.

I UNDERSTAND THAT EYE STUDIO INC. MAY CHARGE A FEE FOR FAILED APPOINTMENTS. A 24 HOUR ADVANCE NOTICE FOR CANCELLATIONS OR TO RESCHEDULE IS EXPECTED

SIGNATURE____ DATE______________

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PATIENT AND FAMILY HEALTH HISTORY: DO YOU OR YOUR BLOOD RELATIVE(S) HAS OR HAD PROBLEMS OF THE FOLLOWING:

	NO	YES	FAMILY
CARDIOVASCULAR			
HIGH BLOOD PRESSURE	___	___	___
HEART DISEASE	___	___	___
NEUROLOGICAL			
HEADACHES	___	___	
MIGRAINES	___	___	
SEIZURES	___	___	
RESPIRATORY			
ASTHMA	___	___	
HEMATOLOGICAL/LYMPHATIC			
ANEMIA	___	___	___
BLEEDING PROBLEMS	___	___	___
EAR, NOSE, MOUTH, THROAT			
ALLERGIES	___	___	
HAY FEVER	___	___	
SINUS CONGESTION	___	___	
BONES, JOINTS, MUSCLES			
RHEUMATOID ATHRITIS	___	___	___
PSYCHIATRIC	___	___	
INTEGUMENTARY (SKIN)	___	___	
ENDOCRINE			
THYROID/ OTHER GLANDS	___	___	___
DIABETES	___	___	___
CANCER	___	___	___

	NO	YES	FAMILY
EYES			
BLINDNESS	___	___	___
GLAUCOMA	___	___	___
CATARACTS	___	___	___
RETINA PROBLEMS /DETACHMENT	___	___	___
MACULAR DEGENERATION	___	___	___
BLURRED VISION AT NEAR	___	___	
BLURRED VISION AT DISTANCE	___	___	
LIGHT SENSITIVITY	___	___	
DOUBLE VISION	___	___	
MUCOUS DISCHARGE	___	___	
DRYNESS	___	___	
REDNESS	___	___	
FOREIGN BODY SENSATION	___	___	
VISION THERAPY	___	___	
ITCHING	___	___	
BURNING	___	___	
EXCESS TEARING	___	___	
EYE PAIN OR SORENESS	___	___	
CHRONIC INFECTION OF EYE OR LID	___	___	
FLASHES/FLOATERS	___	___	
HISTORY OF PATCHING AN EYE	___	___	
EYE INJURY/SURGERY	___	___	
ALLERGIES	___	___	

IF YOU ANSWERED YES TO ANY OF THE ABOVE, OR HAVE A CONDITION NOT LISTED PLEASE EXPLAIN:______________________

____

HAVE YOU HAD ANY RECENT SURGERY? YES / NO. IF YES, EXPLAIN ______________________

____

PLEASE LIST CURRENT MEDICATIONS ______________________

____

MEDICATION ALLERGIES? YES / NO______________________

SOCIAL HISTORY: THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL

DO YOU SMOKE? YES / NO CIGARETTES/TOBACCO DO YOU USE ALCOHOL? YES / NO DO YOU USE ANY OTHER SUBSTANCES? YES / NO

DO YOU DRIVE? YES / NO. IF YES DO YOU HAVE ANY VISUAL DIFFICULTY WHEN DRIVING? YES / NO

IF YES, PLEASE TELL US IN DETAIL:

____

____

Receipt of Notice of Privacy Policies & Consent Form

eye STUDIO

LESLIE CHEN, O.D.
4475 UNIVERSITY AVE., SAN DIEGO, CA 92105
Tel: (619) 521 - 2020

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provide here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; (4)other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purpose of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purpose of treatment, payment, and healthcare operations. I acknowledge that I have received the ***Notice of Privacy Practices*** from EYE STUDIO.

SIGNATURE____ DATE____________

if signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

____________________________ ____________________________
Relationship to Patient Print Name

Source of Authority:____