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

PATIENT REGISTRATION FORM (PRINT CLEARLY)

PATIENT NAME		<u> </u>		TODAY'S DATE
DATE OF BIRTH	/AGE	SSN #		SEX: M D F
STATUS: Single Married	☐ Divorced/Separated	☐ Widowed	CELL PH#()
ADDRESS			HOME PH#()
СІТУ	STATE	ZIP	E-MAIL	·
EMPLOYER		-	WORK P	PH#()
OCCUPATION	0		DO YOU WORK ON A CO	MPUTER? YES/ NOHRS 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				and the second s
HOBBIES / SPORTS / SPECIAL VISU	JAL DEMANDS			
DO YOU WEAR GLASSES?	· ·		*	HOW OLD ARE THEY?
DO YOU WEAR CONTACT LENSES	? YES / NO Į II	F NO, ARE YOU INTERESTED	IN () FUL	L TIME WEAR () OCCASIONAL WEAR
ARE YOU INTERESTED IN CONTAC	T LENSES THAT CORREC	CT YOUR VISION WHILE YOU	SLEEP? YES / N	NO
HAVE YOU HAD REFRACTIVE SUR	GERY/LASIK? Y	ES / NO IF NO,	ARE YOU INTERESTED IN	THE PROCEDURE? YES / NO
	all contact lenses and g	MENT IS EXPECTED WHE		DERED*** balance must be paid before materials are dispensed. W
accept Visa, MasterCard and De	oit Cards.			
Vision (please circle)	No. Co.	to state of Tanastican Division	Gaine Anton	United Health Care DavisVision Molina
Vision Service Plan (VSP) EyeMed Advantica Eye Care		Healthy Families Blue V	fision Aetna	Office Health Care Davisvision (Monta
Medical (please circle)			•	
			PPO (no referral ne	padad)
HMO (referral needed)			PPO (no relettar ne	reded)
I AUTHORIZE THE RELEASE OF AN CHILD DURING THE PERIOD OF S				REATMENT OR EXAMINATION RENDERED TO ME OR MY
I UNDERSTAND THAT NOT ALL 'C COVERED BY INSURANCE, WORK			M FINANCIALLY RESPON	SIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE
I AUTHORIZE AND REQUEST MY	INSURANCE COMPANY	AND/OR GOVERNMENT BEI	NEFITS TO PAY DIRECTLY	TO THE DOCTORS.
I HEREBY GIVE MY PERMISSION DIAGNOSIS AND/OR TREATMEN			AND TREAT WITH SUCH	PROCEDURES AS MAY BE DEEMED NECESSARY IN THE
I UNDERSTAND THAT EYE STUDIO	O INC. MAY CHARGE A F	FEE FOR FAILED APPOINTME	ents. A 24 hour advai	NCE NOTICE FOR CANCELLATIONS OR TO RESCHEDULE IS
SIGNATURE				DATE

eye STUDIO

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

CARDIOVASCULAR HIGH BLOOD PRESSURE HIGH BLOOD PRESSURE HEART DISEASE HEARD PROBLEMS / DETACHMENT HEADACHES MIGRAINES MACULAR DEGENERATION SEIZURES BLURRED VISION AT NEAR RESPIRATORY BLURRED VISION AT DISTANCE ASTRIMA LIGHT SENSTITUTY DOUBLE VISION HEMATOLOGICAL/LYMPHATIC ANEMIA MUCOUS DISCHARGE BLEEDING PROBLEMS DRYNNESS BLEEDING PROBLEMS PROBLEMS PRIVED SENSTITUTY ANEMIA HAY FEVER VISION THERAPY SINUS CONGESTION ITCHING BONES, JOINTS, MUSCLES BURNING RINGHAMPO ATHRITIS EXCESS TEARING RINGHAMPO ATHRITIS EXCESS TEARING RINGHAMPO ATHRITIS EXCESS TEARING RINGHAMPO OF YEAR OLD RINGHAMPO OLD RI		NO YES	FAMILY	San el el Companyo de la companyo d	NO YES	FAMILY
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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. IF YES DO YOU HAVE ANY VISUAL DIFFICULTY WHEN DRIVING? YES / NO	DIABETES CANCER	VE, OR HAVE A	CONDITION NO	EYE INJURY/SURGERY ALLERGIES		
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Receipt of Notice of Privacy Policies & Consent Form

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.

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Print Name
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