Patient's Name ______________________________
Last First Middle

Address ______________________________

____
City State Zip

Home Phone ______________ Work Phone ______________

Mobile Phone ______________ Email ______________

Sex: M F Marital Status: Single Married Divorced Widowed

Social Security ______________ Date of Birth ______________

Primary Care Dr. ______________ Preferred Pharmacy ______________

Primary Care Dr. Phone Nbr. ______________ Pharmacy Phone ______________

Emergency Contact and Phone Nbr. ______________________________

If the patient is under the age of 18, who is responsible for the patient?

Name ______________________________
Last First Middle

Address ______________________________

____
City State Zip

Social Security ______________

Primary Medical Insurance ______________ ID ______________

Subscriber ______________________________
Last First Middle

Date of Birth ______________

Sec. Medical Insurance ______________ ID ______________

Subscriber ______________________________
Last First Middle

Date of Birth ______________

Vision Insurance ______________ ID ______________

Due to new regulations mandated at both the state and federal level, we are now obligated to collect the race, ethnic background and preferred language of each patient. This information will go into your medical record and remains strictly confidential.

Please chose your race

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Other Race or Multiple Races
- White

Please chose your ethnic background

- Hispanic or Latino
- Non Hispanic or Latino

What is your preferred language ______________________________

Please chose how would you prefer to be notified/reminded about future appointments, optical orders and contact lens orders?

- Text message
- Call my mobile number
- Call my work number
- Call my home number
- Email only

I hereby consent to a health examination, related diagnostic procedures and treatments provided by the Eye Center. I hereby authorize my insurance company(s) to remit directly to the Eye Center all payment of benefits otherwise payable to me under the provision of my policy(s). I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to the Eye Center for any services provided to me. I hereby authorize the release of this information needed to determine benefits payable for related services. I also authorize the use of any photographs or data collections taken to document my ocular condition for routine care or use in research and professional publication. Photo static copies of this authorization will be considered valid as the original.

If my insurance company requires referrals, vouchers or authorizations, I will present these to the receptionist immediately. Failure to do so will make me responsible for full payment once services are rendered.

Signature ____

(Please chose one) Patient Parent Legal Guardian Responsible Party

____________ I have received a copy of the "Notice of Privacy Practices"

initial

Berkeley Eye Center

GENERAL HISTORY

Patient Name: ________________________________ **Date:** ___________ **DOB:** ____________ **Sex:** ___ Male ___ Female

1. Allergies: ____

2. Have you had a flu shot this season? ___Yes ___ No

3. If you are over the age of 65, have you had a pneumonia shot? ___Yes ___ No

4. History of the following diseases: Check if yes for Self. For family, please use the following key to describe which family member you're referring to: M= Mother; F= Father; GM= Grandmother; GF= Grandfather; S=Sibling; C= Child; O=Other.

	Self	Family
Cardiac		
1. Heart disease		
2. High blood pressure		
Respiratory		
1. Asthma		
2. Bronchitis		
3. Emphysema		
4. Oxygen dependence COPD		
Neurological		
1. Stroke		
2. Seizures		
Kidney		
1. Renal insufficiency/failure		
2. Dialysis dependence		
Endocrine		
1. Diabetes (Type ________)		
2. Thyroid Problems		
Musculoskeletal		
1. Walker/wheelchair use		
2. Joint pain (Location: _______)		
3. Rheumatoid Arthritis		

	Self	Family
Gastrointestinal		
1. Gastro-esophageal reflux		
2. Hiatal hernia		
Eye Disease		
1. Cataracts		
2. Glaucoma		
3. Macular degeneration		
4. Retinal detachment		
Ear/Nose/Throat		
1. Chronic cough		
2. Hearing aid use		
Psychiatric		
1. Depression		
2. Anxiety		
Other		
1. Cancer (Type: ______________)		
2. Cholesterol		
3. Lupus		
4. Bleeding disorders (Type: ___________________________)		
5. HIV		
6. Hepatitis (Type: ____________)		
7. __________________________		

5. Current medications:

____

____

6. Previous surgeries: ____

____

7. Do you smoke? ___Yes ___ No **Do you use smokeless tobacco?** ___Yes ___ No Quantity: ____________________

If you quit, how long ago? ____

8. Alcohol consumption? ___Yes ___ No Quantity: ____

9. Drug abuse? ___Yes ___ No Type: ______________________________________

10. If you are female, possibility of pregnancy or breastfeeding? ___Yes ___ No

11. Do you have an Advanced Directive for Healthcare (Living Will) ___Yes ___ No

12. Do you suffer from any of the following?

Blurry vision _____ Sinus problems _____ Watery eyes _____ Pain in your eyes _____ Dizziness _____ Floaters _____

Dry eyes _____ Seasonal allergies _____ Headaches _____ Flashes of light _____ Halos _____ Other _____

13. Do you wear glasses? ___Yes _____ No **Do you wear contact lenses?** ___Yes ___ No **If yes:** ___ Hard ___Soft

Brand: ____________________________________ **Power**: Right____ Left____ **How many hours per day?**______

Berkeley Eye Center
Caplan Surgery Center

Authorization of Use and Disclosure of Protected Health Information for Individuals

Persons Authorized to Receive Information:
Health information Berkeley Eye Center/Caplan Surgery Center collects or received about you may be disclosed to the following persons:

____
Name of person   Relation

____
Name of person   Relation

Use and Disclosure of Information:
I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Berkeley Eye Center/Caplan Surgery Center.

Expiration Date of Authorization
This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Berkeley Eye Center/Caplan Surgery Center. You should contact our Privacy Officer to terminate this authorization.

Potential to Re-disclosure
The person to whom health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Signature

___________________________________   ____________________
Signature of Patient   Date

____
Name of Patient (Print or Type)

___________________________________   ____________________
Signature of Patient Representative   Relationship to Patient