San Francisco Eye Institute

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PATIENT MEDICAL HISTORY RECORD

_____ _____ _____ _____

PATIENT'S NAME TODAY'S DATE BIRTH DATE AGE

WHAT IS THE REASON FOR YOUR VISIT TO OUR OFFICE? _____

Please answer the following questions about your medical status and history:

1. Are you currently or have been treated for any medical conditions: (e.g. diabetes, high blood pressure, arthritis, etc.)
   Yes □ No □ If YES, please explain: _____
2. Please circle if you have: Asthma, Diabetes, High Blood Pressure, Arthritis, Thyroid, or Immune System Diseases
3. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy eye", retinal detachment)?
   Yes □ No □ If YES, please explain: _____
4. Have you ever had any surgery:
   Yes □ No □ If YES, please provide date and reason: _____
5. Have you ever been hospitalized:
   Yes □ No □ If YES, please provide date and reason: _____
6. Do you take any medications:
   Yes □ No □ If YES, please list: _____
   Do you take any eye medications:
   Yes □ No □ If YES, please explain: _____
7. Do you have any drug or food allergies:
   Yes □ No □ If YES, please list: _____
8. Are you taking Flomax? YES NO

Review of Systems	Yes	No	If YES, please explain
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss/gain, fatigue	□	□	_____
Ear/Nose/Throat problems (e.g. hearing loss, sinus problems, sore throat)	□	□	_____
Heart problems (e.g. chest pain, irregular heartbeat)	□	□	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	□	□	_____
Abdominal Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	□	□	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	□	□	_____
Skin problems (e.g. rashes, excessive dryness)	□	□	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	□	□	_____
Neurological problems (e.g. numbness, weakness, headaches, paralysis)	□	□	_____
Psychiatric problems (e.g. depression, anxiety)	□	□	_____

Family and Social History

Do any medical or eye disease run in your family:(e.g. diabetes, high blood pressure, cancer, glaucoma,macular degeneration)

Yes □ No □ If YES please explain _____

Do you smoke? Never / Former / Current If YES, how much per day_____

Do you drink alcohol? YES □ NO □ If YES, □ occasional , □ more than 4/day

Do you drive? YES □ NO □ Do you have any difficulty driving? YES □ NO □

PLEASE CIRCLE IF YOU USE: GLASSES CONTACT LENSES

PLEASE CIRCLE IF YOU ARE HERE FOR OF IF YOU ARE INTERESTED IN:

NEW GLASSES CONTACT LENSES CONSULT VISION CORRECTION CONSULT

PATIENT SIGNATURE _____ DATE _____

AUTOMATIC INSURANCE CLAIM SUBMISSION/ASSIGNMENT OF BENEFIT

Payment is due at the time of service. Persons who carry medical insurance should remember that professional services are rendered and charged to the patient and not the insurance company. At your request, our company can automatically submit claim forms to your insurance company on your behalf. This is offered to our patients as a courtesy only.

Please fill out the insurance information or present us with your insurance card for photocopying and sign in the indicated spaces below. We will send claim forms once per week to primary insurance carriers only. Please be aware that you will need to carefully monitor these claims. You will be responsible for submitting claims regarding any secondary carrier you may have.

I hereby request that payment of authorized benefits (i.e., Medicare or any other insurance) that I have, be made on my behalf to the San Francisco Eye Institute for any services furnished to me. I authorize any holder of medical information about me to release it to the Health Care Finance Administration and its agents or any other insurance company with information needed to determine these benefits or the other benefits payable for related services. I ALSO AGREE TO PAY FOR ALL "NON –COVERED SERVICES", INCLUDING REFRACTIONS AND CONTACT LENSES.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance.

I have been informed that my **medical** insurance company does not cover refractions (92015) and therefore agree to be fully responsible for the charge of $120.00.

Patient signature _____ Date _____

INFORMED CONSENT FOR DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eyes to allow the ophthalmologist/optometrist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and make bright lights bothersome. It is not possible for your ophthalmologist/optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

I hereby authorize The San Francisco eye Institute and/or such assistants as may be designated by her/him to administer dilating drops. The eye drops are necessary to diagnose my condition.

Patient Signature _____ Date _____