PATIENT INFORMATION SHEET

Date: _____

Name:_____ Birth Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone (H):_____ Cell:_____

Social Security #:_____Email:_____

Employer:_____

Referred by:_____

MEDICAL HISTORY QUESTIONNAIRE

Sex: ____ M_____F

Height:_____ Weight:_____

Primary Care Physician:_____

Opthamologist/Optometrist:_____

Please list ALL eye conditions and previous eye surgeries/procedures:

1._____

2._____

3._____

Please list ALL eye medications and how often you use them and in which eye.

1._____

2._____

3._____

4._____

Do you have any of the following: (Please circle)

Diabetes, High Blood Pressure, Asthma, Stroke, Heart Disease, Arthritis, HIV, Hepatitis

Cancer, Thyroid Disease, Depression, Anxiety

Please list any other conditions:

1._____

2._____

Please list ALL past surgeries.

1._____

2._____

Please list ALL medications, the dosage and how frequently taken.

1._____

2._____

3._____

Allergic to ANY medications? Y_____ N_____

If YES please list

1._____

2._____

Do you have a Family History of Eye Disease? Please list.

1._____

Do you smoke? Y_____ N_____

Have you smoked in the past? Y_____ N_____

Do you drink alcohol? Y_____ N _____

What is your occupation? _____

Do you currently drive? Y_____ N_____

Marital Status: Single:_____Married:_____Divorced:_____Widowed:_____

Is there anyone you want to AUTHORIZE to discuss your medical condition(s) with the doctor?

Please LIST:

1._____

2._____

_____ _____

Patient signature Date

COACHELLA VALLEY
RETINA

Dear_____(Patient name).

We ask that you please read and sign below.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each policy. Therefore, we urge you, the patient, to check with your insurance company regarding your coverage. It is your responsibility to know your coverage and insurance policy and limitations. Failure to comply with this suggestion could result in you, the patient being responsible for all of the costs incurred during your visit today_____2016.

_____

Print name

_____

Signature

Please circle all that apply:

Ethnicities:

- Hispanic origin
- Not of Hispanic origin
- Patient declines

Race:

- American Indian or Alaskan native
- Asian
- African American
- Native Hawaiian or Pacific Islander
- Caucasian
- Patient declines

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Patient name:_____ Date of birth_____

Address: _____ City/State/Zip code_____

I, hereby AUTHORIZE the disclosure of my Health Information from:

Name of Person/Organization Releasing Information

Address City/State/Zip code

_____

Phone number/Fax number

To RELEASE my information to:

Coachella Valley Retina
72-301 Country Club Drive, Suite 108
Rancho Mirage, CA 92270
(T) 760 895-1993 (F) 760 862-1992

INFORMATION TO BE RELEASED

_____Complete Medical Record

_____Medical Records for Specifics Dates of Service (please list) from_____to_____

_____Other (please list)

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subjective to disclosure by the recipient and may no longer be protected by Federal of State law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPAA). I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I

have the right to refuse the signing of authorization and that my treatment will not be conditioned on signing.

_____ _____

Printed name of Patient/ Signature of Patient

Personal Representative

_____ _____

Description of Personal Representative's Authority Date

Date sent:_____ By:_____ Via:_____