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

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:__________________