DATE _____ REF M.D _____, ____ 1 MULT LOCATION _____ PHONE _____

Patient Information Sheet

_____

LAST NAME FIRST M.I AGE SEX D.O.B OCCUPATION

_____

STREET ADDRESS

_____

CITY STATE ZIP HOME PHONE CELL PHONE

_____

EMPLOYER ADDRESS CITY STATE ZIP WORK PHONE

_____

SSN # DRIVERS LICENSE # MARITAL STATUS

_____

SPOUSE NAME SPOUSE EMPLOYER CITY STATE ZIP PHONE NUMBER

_____

EMERGENCY CONTACT RELATIONSHIP PHONE NUMBER

---–----------–----------**INSURANCE INFORMATION**----------

_____

PRIMARY INSURANCE INSURANCE ADDRESS CITY STATE ZIP

_____

SUBSCRIBER NAME I.D. NUMBER SEX D.O.B PHONE

_____

SECONDARY INSURANCE INSURANCE ADDRESS CITY STATE ZIP

_____

SUBSCRIBER NAME I.D. NUMBER SEX D.O.B PHONE

DO YOU HAVE A CO-PAYMENT? YES [ ] NO [ ] AMOUNT $_____
HAVE YOU BEEN TO ANY OF OUR OFFICES PREVIOUSLY FOR ANY REASON? YES [ ] NO [ ]

VISIT DATE _____ CAP? YES [ ] NO [ ] AUTH FOR _____ VERIFIED? YES [ ] NO [ ] DATE _____

DATE _____ REF M.D _____, ____ 1 MULT LOCATION _____ PHONE _____

Patient Information Sheet

-----–-----–-–-----TREATMENT/PAYMENT AUTHORIZATION TO ORANGE COUNTY RETINA----------

Permission is granted for examination, diagnosis and treatment for any medical condition I may be diagnosed with. I hereby authorize Orange County Retina (OCR) to furnish information to my insurance carrier(s) concerning this medical condition unless otherwise noted. Permission is also given to release information to other physicians as necessary for the treatment of my condition. I hereby irrevocably assign to the doctor responsible for my care all payments for medical services rendered if said services have not been paid in full at the time of service. As a courtesy to me I understand my insurance company will be billed for medical services, I further understand that insurance billing does not guarantee payment to the doctor. I understand the doctor will refund any applicable overpayment for services rendered. **I understand that I am financially responsible for all incurred charges regardless of insurance coverage.** I agree that in the event of default for any amount due to cover any additional charges equal to the cost of collection, including but not limited to agency, attorney fees and/or court costs as permitted by California law.

_____

SIGNATURE DATE

OFFICE ONLY: Change this sheet if Insurance Category changes. Put under new Reg. Sheet. **STAFF INITIALS**_____
Reg Sheet < 3 mo? [ ] Ref M.D Location, phone [ ] Phone # Verified [ ] DL Copy [ ] All Bullets Filled [ ]
Ins Hard Copy? [ ] Coverage Verified? [ ] Author Necessary? Yes [ ] No [ ] Copay-Deduct Collected? Yes [ ] Envelope [ ]

CIRCLE ONE: CSH P WC MON HMO PPO IPA ECA POS MC MM CalOpt CCS

VISIT DATE _____ CAP? YES [ ] NO [ ] AUTH FOR _____ VERIFIED? YES [ ] NO [ ] DATE _____

orange county retina

Medical History Form

Name: _____ **Birthdate:** _____/_____/_____

Who referred you (if no one – how did you find us)? _____ Fax: _____
Primary Care Physician Name: _____ Location: _____ Fax: _____
Do you want a report sent to other doctors (eg Endocrinologist)? _____ Fax: _____

EYE HISTORY

Main eye complaint (reason for visit): _____ Started When?: _____

Have you been diagnosed with any of the following?

- ❒ Cataracts ❍ R ❍ L
- ❒ Glaucoma ❍ R ❍ L
- ❒ Macular Degeneration ❍ R ❍ L
- ❒ Retinal Detachment ❍ R ❍ L
- ❒ Diabetic Retinopathy ❍ R ❍ L

Previous eye surgeries (including laser surgery):

1. _____ ❍ R ❍ L Date: _____
2. _____ ❍ R ❍ L Date: _____
3. _____ ❍ R ❍ L Date: _____
4. _____ ❍ R ❍ L Date: _____
5. _____ ❍ R ❍ L Date: _____

Current Eye Drops: ❒ **No Current Eye Drops**

1. _____ ❍ R ❍ L ___x/day
2. _____ ❍ R ❍ L ___x/day
3. _____ ❍ R ❍ L ___x/day
4. _____ ❍ R ❍ L ___x/day

MEDICAL HISTORY - Have you ever been diagnosed with any of the following?

❒ Heart disease / Murmur	❒ Emphysema	❒ Sickle Cell Disease	❒ Diabetes
❒ High cholesterol	❒ Asthma	❒ Kidney / Bladder problems	❒ Seizures
❒ High blood pressure	❒ Lung problems / cough	❒ Liver problems / Hepatitis	❒ Stroke
❒ Low blood pressure	❒ Sinus problems	❒ Headaches / Migraines	❒ Arthritis
❒ Heartburn (reflux)	❒ Seasonal allergies	❒ Neurological problems	❒ Cancer
❒ Anemia or blood problems	❒ Tonsillitis	❒ Depression / Anxiety	❒ Ulcers/colitis
❒ Swollen ankles	❒ Ear problems	❒ Psychiatric care	❒ Thyroid problems

❒ Other: _____

SURGICAL HISTORY – Please list any major surgeries:

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____

SOCIAL HISTORY

❒ Alcohol: ❍ Never ❍ Social ❍ Frequent
❒ Tobacco: ❍ Never ❍ Past ❍ Current
_____packs/day x _____years
❒ Other Drugs: _____

FAMILY HISTORY

	Mother	Father	Sibling	Other
Eye Problems				
Cataract	❒	❒	❒	❒____
Glaucoma	❒	❒	❒	❒____
Retinal Detachment	❒	❒	❒	❒____
Macular Degeneration	❒	❒	❒	❒____
Other: _____	❒	❒	❒	❒____

	Mother	Father	Sibling	Other
Medical Problems				
Diabetes	❒	❒	❒	❒ ____
Cancer	❒	❒	❒	❒ ____
Heart Disease	❒	❒	❒	❒ ____
Other: _____	❒	❒	❒	❒ ____
Other: _____	❒	❒	❒	❒ ____

OCCUPATION _____ ❒ Retired ❒ Unemployed ❒ Disabled

MARITAL STATUS ❒ Married ❒ Single ❒ Divorced ❒ Separated ❒ Widower

orange county retina

Medical History Form

ALLERGIES - list all allergies to medications and/or other substances

1. _____ Reaction:_____
2. _____ Reaction:_____
3. _____ Reaction:_____
4. _____ Reaction:_____

❒ **No Known Allergies**

❒ Fluoresceine Dye Reaction:_____
❒ Iodine Reaction:_____
❒ Latex Reaction:_____
❒ Anesthetics Reaction:_____

MEDICATIONS – list all current medications or provide a list

❒ **No Medications**

1. _____ Dose:_____
2. _____ Dose:_____
3. _____ Dose:_____
4. _____ Dose:_____
5. _____ Dose:_____
6. _____ Dose:_____
7. _____ Dose:_____
8. _____ Dose:_____
9. _____ Dose:_____
10. _____ Dose:_____

REVIEW OF SYSTEMS – please indicate if you are experiencing any of the following

General
❒Unexplained weight loss / gain
❒Unexplained fatigue / weakness
❒Fall asleep during day
❒Fever, chills
❒**No problems**

Skin
❒New or change in mole
❒Rash / itching
❒**No problems**

Breast
❒Breast lump / pain / nipple discharge
❒**No problems**

Ears/Nose/Throat
❒Nosebleeds, trouble swallowing
❒Frequent sore throat, hoarseness
❒Hearing loss / ringing in ears
❒**No problems**

Eyes
❒Change in vision / eye pain / redness
❒**No problems**

Cardiovascular
❒Chest pain / discomfort
❒Palpitations
❒**No problems**

Respiratory
❒Cough / wheeze
❒Loud snoring / altered breathing during sleep
❒Short of breath with exertion
❒**No problems**

Gastrointestinal
❒Heartburn / reflux / indigestion
❒Blood/change in bowel movement
❒Constipation
❒**No problems**

Genitourinary
❒Leaking urine
❒Blood in urine
❒Nighttime urination or increased frequency
❒Discharge: penis or vagina
❒Concern with sexual function
❒**No problems**

Musculoskeletal
❒Neck pain
❒Back pain
❒Muscle / joint pain _____
❒**No problems**

Endocrine
❒Heat or cold sensitivity
❒**No problems**

Hematologic/Lymphatic
❒Swollen glands
❒Easy bruising
❒**No problems**

Neurological
❒Headache
❒Memory loss
❒Fainting
❒Dizziness
❒Numbness / tingling
❒Unsteady gait
❒Frequent falls
❒**No problems**

Allergic/Immune
❒Hay fever / allergies
❒Frequent infections
❒**No problems**

Psychiatric
❒Anxiety / stress / irritability
❒Sleep problem
❒Lack of concentration
❒**No problems**

SIGNATURE: **DATE:**

X_____ _____/_____/_____

By signing here, you are indicating that the above information is correct to the best of your knowledge and applies to only you.

orange county retina

ELIGIBILITY GUARANTEE FORM

I, [**Patient Name**] _____ _____ hereby certify that I am eligible under the following health insurance company, _____, and under the subscriber [**Insured Name**] _____ through his / her employer_____. I also certify that I have chosen Orange County Retina Medical Group (Dr. Maggiano, Dr. You, Dr. Chen, Dr. Rathod, Dr. Kim) to be my medical provider through _____ medical group. I understand that if the above is not true, or if I am not eligible under the terms of my Medical and Subscriber Agreement, I am liable for any and all charges for services rendered within thirty (30) days of receiving a bill from the above noted medical group / physicians.

_____
Signature of Member (or patient if member is not available)

_____
Verified By [OCR Staff]

_____
Date

orange county retina

HIPPA Patient Consent Form

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to Orange County Retina Medical Group (OCR) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care options (TPO). [OCR Notice of Privacy Practices describes such uses and disclosures in their extent.] I have been given the Notice of Privacy Practices prior to signing this consent. OCR reserves the right to revise its Notice of Privacy Practices at any time.

With this consent, OCR may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. This includes, but is not limited to; appointment reminders, insurance items, laboratory test results, and calls pertaining to appointments.

With this consent, OCR may mail to my home, or other alternative locations, any items that assist the aforementioned practice in completing TPO. This includes, but is not limited to; appointment reminders, insurance items, laboratory test results and patient billing statements.

With this consent, OCR may electronically mail (e-mail) to my home, or other alternative locations, any items that assist the aforementioned practice in completing TPO. This includes, but is not limited to; appointment reminders, insurance items, laboratory test results and patient billing statements. By signing this consent, I acknowledge that I have the right to request that OCR restrict how it uses or discloses my information to complete TPO. The practice is not required to agree to my requested restrictions, however if OCR complies with my requests, it is bound by this agreement.

By signing this form, I am consenting to allow OCR to use and disclose my personal information to carry out my treatment options.

I may revoke my consent in writing, limited to the extent that the practice has already disclosed my personal information, prior to my revocation. If I refuse to sign this consent, or choose at a later date to revoke my consent, OCR may refuse to provide treatment to me if they so choose.

_____

Signature of Patient [or Legal Guardian]

_____ _____

Print Patient's Name Date

_____

Print Name of Legal Guardian [if applicable]

orange county retina

DEMOGRAPHICS, PRIMARY CARE PROVIDER & PHARMACY

FEDERAL LAW REQUIRES YOU TO PROVIDE US WITH THE FOLLOWING INFORMATION

PATIENT NAME:	DATE OF BIRTH:	SEX:
PREFERRED LANGUAGE:	E-MAIL ADDRESS:	

ETHNICITY:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline to specify

RACE:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Caucasian
- ☐ Other:
- ☐ Decline to specify

PHARMACY INFORMATION

PHARMACY NAME:			
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	FAX NUMBER:		

REFERRING PROVIDER

NAME & TITLE:			
ADDRESS:	CITY:	STATE:	ZIP CODE:
OFFICE PHONE:	FAX:	E-MAIL:	
SPECIALTY:			

PRIMARY CARE PROVIDER

NAME & TITLE:			
ADDRESS:	CITY:	STATE:	ZIP CODE:
OFFICE PHONE:	FAX:	E-MAIL:	
SPECIALTY:			

orange county retina

Office Policies

1. **Un-Kept Appointment Charge** - We reserve the right to charge for any un-kept appointment not cancelled within 24 hours of the scheduled appointment time. The appointment must be cancelled with at least one (1) business day notice, Monday through Friday (not Saturday or Sunday). **<u>This charge is not covered by your insurance.</u>**

   Late Appointment Cancellation or "No Show" Charge: Office Visit $100

2. **Form Completion Charge –** There may be a charge for each form or letter a patient requests us to complete. If forms or reports are lengthy, charges may be higher depending on the amount of time spent on completion.

   Our charges are as follows:

DMV Forms	$25
Long Term Care Ins.	$25
Disability Form	$25
FMLA	$25
Jury Duty Letter	$25
Letter from Physician	$25

3. **Returned Check Charge –** Any personal checks for payments returned from the bank, for any reason, will be charged a check return fee: Check Return Charge $25 **<u>This charge is not covered by your insurance.</u>**

4. **Co-Payments and Deductibles – Patients are required to pay their co-payments and any deductible at the time of the office visit.** This is a contractual obligation between you and your health plan. Failure to pay your co-payment and/or deductible may result in denial of service(s). We accept cash, debit cards, VISA®, and MasterCard®.

5. **Medical Records –** There is a charge of copying your medical records and transferring them to another physician. **The charge starts at $25 plus any postage fees.** Our Front Desk personnel will assist you with the processing of your request.

By signing below, I acknowledge and agree to the above office policies.

Patient Name (Please print): _____

Signature: _____

Date: _____

Is there a family member with whom we may discuss your medical history? If so, please list:

_____