Irvine Eye Physicians and Surgeons, Inc.

Welcome! Thank you for choosing our office.

In order to serve you properly, we will need the following information. (Please print.) All information is strictly confidential.

PATIENT INFORMATION:

Name_____ Date of Birth _____ Sex ____ SSN_____
Mailing Address_____ City _____ State _____ Zip _____
❒ Cell ❒ Home Phone Number _____ Email Address _____
Occupation_____ Employer_____ Marital Status [❒Single] [❒Married] [❒Widowed] [❒Divorced]
Are you of Hispanic Origin? [❒Yes (Please specify)_____] [❒Not Hispanic or Latino]
Race [❒Asian] [❒Black or African American] [❒Other Pacific Islander] [❒White] [❒Other:_____] [❒Decline]
Preferred Language [❒English] [❒ Español] [❒中文] [❒Other:_____]
Parent or Guardian Name (*If under 18 years old*)_____ Relationship_____
Emergency Contact _____Relationship_____Phone Number_____

INSURANCE INFORMATION: ❒ ***I <u>do not</u> have medical insurance***

Medical Insurance

Insurance Name_____ Primary Policyholder's Name_____
Member ID Number_____ Primary Policyholder's DOB_____
Policy Group Number_____ Plan Name_____

Vision Insurance ❒ ***I <u>do not</u> have vision insurance***

❒ Vision Service Plan (VSP) ❒ EyeMed/Blue View Vision Member ID (If available)_____
Primary Policyholder's Name_____ Primary Policyholder's DOB_____

PERSONAL MEDICAL HISTORY (*Please check all that apply*):

[❒High blood pressure] [❒Diabetes - Type 1❒ Type 2❒] [❒High cholesterol] [❒Asthma] [❒Hypothyroidism] [❒Arthritis]
[❒Stroke] [❒Heart disease] [❒Sleep Apnea] [❒Cancer (Please specify)_____] [❒Other_____]
Current Medications (❒None)_____
Drug Allergies (❒ None)_____
Do you smoke? [❒Yes (*Frequency?*)_____] [❒Former Smoker] [❒Never Smoked]
Do you consume alcohol? [❒Yes (*Frequency?*)_____] [❒No]
[❒Operations/surgeries (Please list)] Type and Date_____
Name of primary care doctor_____ Office Phone Number_____

PERSONAL EYE HISTORY:

What is your chief complaint today?_____
Personal Eye History (*Please check all that apply*)
[❒Glasses][❒Contacts][❒Glaucoma][❒Macular degeneration][❒Retinal detachment][❒Other_____]
[❒Eye Operations/Surgeries] Type and Date_____

FAMILY HISTORY (<u>*Please specify family member relation for each condition*</u>):

[❒High blood pressure_____] [❒ Diabetes_____] [❒Glaucoma_____]
[❒Macular Degeneration_____] [❒Retinal Detachment_____] [❒Heart disease_____]
[❒Cancer (please specify)_____] [❒ Other_____]

Please carefully review and check the following

❒ I authorize this office to release any information necessary to expedite insurance claims. **I understand that I am responsible for all charges, <u>*regardless of insurance coverage*</u>.**

❒ I hereby authorize the use or disclosure of my individually identifiable health information as described in the "NOTICE OF PRIVACY PRACTICES" document available at www.drchia.com/appointments or upon request at our office.

❒ I understand medical insurance doesn't always cover routine exams as ophthalmologists are specialists. Once a claim is submitted, it can't be canceled or resubmitted to another policy.

Patient, Parent or Guardian Signature_____ Date_____