Name Date

Date of Birth ______________________________

List any **medications** you currently take (Rx and over-the-counter):______________________________

____

Do you have **ALLERGIES** to any medications: YES___ NO___

If **YES**, list the medications:______________________________

____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

____

____

List any surgeries you have had (cataract, appendectomy): ______________________________

Are you interested in getting rid of glasses? Yes___ No___

Would you like to hear more about LASIK? Yes___ No___

Refractive Lens Exchange is a procedure where the old lens in your eye is removed and replaced with a new one that can help you see both far and near. Would you like to hear more about this? Yes___ No___

Do you *currently* have any problems in the following areas? Please provide additional information.

	Yes	No	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat, stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, heart disease, etc.)			
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? YES/ NO/ UNK

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other:

SOCIAL HISTORY

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If YES, how much?______________________________

Do you smoke? YES NO If YES, how much?______________ How many years?______________

Physician's Signature______________________________ Date______________________________

EYE PHYSICIANS OF LONG BEACH, A MEDICAL GROUP, INC.

PATIENT'S INFORMATION

DATE ____________________

Patient's Name ____________________ Spouse ____________________

If minor, name of responsible party: ____________________

Address ____________________ Apt. # ____________

City ____________________ State ______ Zip ____________

Home Phone (_______) ____________________ Driver's License # ____________________

Age ____________ Marital Status ____________________

Social Security # ____________________ Birth Date ____________ Sex (F/M) ____________

Patient's Employer ____________________ Occupation ____________________

Address ____________________ Work Phone (_______) ____________

City ____________________ State ______ Zip ____________

How were you referred to this office? ____________________

PRIMARY INSURANCE INFORMATION

Insurance Co. Name ____________________ Group/Policy # ____________________

Insurance Address ____________________

Insured's Name ____________________ Date of Birth ____________

Insured's Address ____________________

Insured's Social Security # ____________________

Patient relationship to insured: Self Spouse Child

Please complete the following if insured is other than self.

Insured's Employer ____________________ Occupation ____________________

Address ____________________ Work Phone (_______) ____________

City ____________________ State ______ Zip ____________

SECONDARY INSURANCE INFORMATION

Insurance Co. Name ____________________ Group/Policy # ____________________

Insurance Address ____________________

Insured's Name ____________________ Date of Birth ____________

Insured's Address ____________________

Insured's Social Security # ____________________

Patient relationship to insured: Self Spouse Child

Please complete the following if insured is other than self.

Insured's Employer ____________________ Occupation ____________________

Address ____________________ Work Phone (_______) ____________

City ____________________ State ______ Zip ____________

Patient Consent for Use and Disclosure of Protected Health Information

1. With my consent, **Eye Physicians of Long Beach, a Medical Group, Inc.** may use and disclose Protected Health Information (**PHI**) about me to carry out Treatment, Payment, and healthcare Operations (**TPO**). Please refer to Eye Physicians of Long Beach **Notice of Privacy Practices** for a more complete description of such uses and disclosures.
   a. I have the right to review the **Notice of Privacy Practices** prior to signing this consent.
   b. **Eye Physicians of Long Beach, a Medical Group, Inc.** reserves the right to revise its **Notice of Privacy Practices** at any time. A future revised **Notice of Privacy Practices** may be obtained by forwarding a written request to **Eye Physicians of Long Beach, a Medical Group, Inc.** at 3325 Palo Verde Ave., Suite 103, Long Beach, CA 90808-4132.
2. With my consent, **Eye Physicians of Long Beach, a Medical Group, Inc.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items, and any call or FAX pertaining to my clinical care, including laboratory results, prescriptions for medications, prescriptions for glasses and contact lenses, the making of the lenses for the glasses, and any other detail of providing the best possible service to me.
3. With my consent, **Eye Physicians of Long Beach, a Medical Group, Inc.** may mail or FAX to my home or other designated location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards, patient statements, prescriptions for medications or prescriptions for glasses or contact lenses.

I have the right to request that **Eye Physicians of Long Beach, a Medical Group, Inc.** restrict how it uses or discloses my **PHI** to carry out **TPO**. However, this office is not required to agree to my requested restrictions; but, if it does, it is bound by this agreement. I hereby consent to the use of my **Protected Health Information** in the manner indicated in items one through three. No further consent is required and this consent will remain effective until I request otherwise in writing.

____________________________ _______________

Signature Date

Financial Responsibilities

It is understood and agreed that I shall notify **Eye Physicians of Long Beach, a Medical Group, Inc.** of any change (s) in my insurance and that I shall be personally responsible for all costs incurred due to any charge(s) in the event that notification is not made. Many insurances, including Medicare, do not pay for refractions. If a refraction (the portion of the exam to determine the glasses prescription) is performed I understand I may be responsible for the cost.

I authorize payment of benefits to **Eye Physicians of Long Beach, a Medical Group, Inc.** for medical services rendered. It is understood and agreed that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate that said account then I shall be personally liable for the unpaid balance of the account. In the event of default, I may also be responsible for collection costs, a reasonable rate of interest, and/or reasonable attorney's fees.

____________________________ _______________

Signature Date