EYE PHYSICIANS
OF LONG BEACH

Carlos E. Martinez, M.D.
James W. Donovan, M.D.
Eli L. Chang, M.D.
Diplomats, American Board of Ophthalmology

Name: _____ Date of birth: _____ Date: _____

List any medications you currently take (please include prescription and over-the-counter): _____

_____

_____

Do you have any medication **ALLERGIES**? YES NO (if "YES", please list) _____

_____

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

_____

List any surgeries you have had (cataract, appendectomy, etc.) _____

_____

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 blood pressure, heart disease, 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, etc.)			
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 / UNKNOWN
-Blindness, -Cataract, -Glaucoma, -Diabetes, -High blood pressure, -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 many a day? _____
How many years? _____

Physician's Signature _____ Date _____

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Patient Information

First Name:_____

Last Name:_____

Middle Initial:_____Marital Status: S M D W

Spouse Name:_____

Address:_____

City / State / Zip:_____

E-mail:_____

Primary Phone: (_____)_____ cell / wk / hm

Secondary Phone: (_____ cell / wk / hm

Sex: M F Birth Date:_____Age:_____

Social Security Number:_____

Driver's License #:_____

Occupation:_____

Employer:_____

City: _____ State/Zip:_____

How did you hear about our office?_____

Emergency Contact **NOT LIVING WITH YOU**:

Name:_____

Relationship:_____

Address:_____

_____

Phone: (_____)_____ cell / wk / hm

Primary Care Physician:_____

Address:_____

_____

Phone: (_____)_____

Primary Insurance

Insurance Co. Name: _____

Group/Policy #:_____

Insurance Address:_____

Insured's name:_____

Patient relationship to insured: Self Spouse Child

Secondary Insurance

Insurance Co. Name:_____

Group/Policy #:_____

Insurance Address:_____

Insured's name:_____

Patient relationship to insured: Self Spouse Child

*Due to Electronic Medical Records we will be asking to take your photo to correspond with your medical record.

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 **P**rotected **H**ealth **I**nformation (**PHI**) about me to carry out **T**reatment, **P**ayment, and healthcare **O**perations (**TPO**). Please refer to **Eye Physicians of Long Beach** Notice of Privacy Practices for a more complete description of such uses and disclosures.
    - I have the right to review the Notice of Privacy Practices prior to signing this consent.
    - **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 mail, fax, email, 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, fax or email 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.

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 and two. 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