PENINSULA
OPHTHALMOLOGY GROUP

PATIENT INFORMATION

*(Please **PRINT CLEARLY** and fill in **ALL** areas)*

NAME: ____ **SEX:** ☐ Male ☐ Female
First Middle Last ☐ Single ☐ Married ☐ Other

ADDRESS: ____

CITY:______________________________ **STATE**:__________ **ZIP CODE**: __________

HOME PHONE#: (______) ______-_________ **WORK PHONE#:** (_____) ______-________

CELL PHONE#: (______) ______-_________ **EMAIL ADDRESS:** ______________________

BIRTH DATE: _____/_____/______ **SOCIAL SECURITY#:** _______ - _______ - ________

EMPLOYER'S NAME: ____________________________ **OCCUPATION**: ______________

ADDRESS: ____

CITY:______________________________ **STATE**:__________ **ZIP CODE**: __________

PRIMARY MEDICAL INSURANCE:____________________________ **ID#**_______________

SUBSCRIBER NAME:__________________________ **DATE OF BIRTH**:___/___/_____

SECONDARY MEDICAL INSURANCE:__________________________ **ID#**_______________

SUBSCRIBER NAME:__________________________ **DATE OF BIRTH**:___/___/_____

VISION INSURANCE: ____________________________________ **ID#**_______________

SUBSCRIBER NAME:__________________________ **DATE OF BIRTH**:___/___/_____

EMERGENCY CONTACT: _________________________ ***RELATIONSHIP***: ______________

EMERGENCY PHONE#: (______) ________-_______________

Were you referred by anyone?
NAME: ____ ***RELATIONSHIP***: ______________

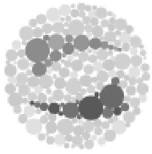
I authorize release of any medical information necessary to process my claims, and payment of medical benefits to this provider for services rendered.

I also acknowledge and assume full financial responsibility for the health care services rendered to me if these are not covered under my insurance plan; or the services have otherwise not been approved for payment by my insurance plan; or my eligibility is not in effect as of the date of service.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

________________________________ ____________
Member's Signature (or Legal Representative) DATE

For Office Use: Entered by: _____



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Office Policies, *UPDATED 7/1/2013*

LATE ARRIVALS:
If you are more than 15 minutes late for your appointment time, we will try our best to fit your visit into the clinic schedule; however, there may be a wait since there may be other scheduled patients and we cannot guarantee that we will have sufficient time to complete your exam. We would be glad to reschedule your visit if you would prefer.

MISSED APPOINTMENTS:
We require a 24-hour notice of cancellations. Missed appointments are lost opportunities for other patients. There is a $50 charge for appointments missed without 24-hour prior notice.

CO-PAYMENTS:
Insurance companies require us to collect your co-payment at the time of your visit. If you wish us to bill you for this co-payment, there will be an administrative charge of $25.00.

FORMS:
There is a $15.00 fee per form for completion of DMV, state disability, or miscellaneous paperwork.

RETURNED CHECKS:
Patients with checks returned unpaid from the bank will be charged $50.00 per check to cover bank fees and processing.

OUTSTANDING BALANCES:
Balances outstanding beyond 30 days after the date billed are subject to interest at a rate of 1½% per month. Unpaid balances past 90 days are automatically sent to an outside collection agency.

CONTACT LENSES:
If you wear contact lenses, some or all of these services may not be covered by your insurance company. Details for fees and services are available on our *Contact Lens Information Sheet* which is available at the front desk.

I have been informed of the Peninsula Ophthalmology Group's Office Policy.

Signature: ____________________________ Date: _________________

Print Name: ___________________________

If not signed by the patient, please indicate relationship:
- ˇ parent or guardian of minor patient
- ˇ guardian or conservator of an incompetent patient

Name of Patient: _________________________________

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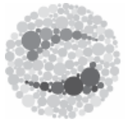


MEDICAL HISTORY QUESTIONNAIRE

Name: ________________________________ **Age:** _______ **Today's Date:** __________

Primary Care Doctor: Name: ________________________ Location (city): ______________

PAST MEDICAL HISTORY

Allergies: (List all medications that have caused an allergic reaction) **[None]**

________________ ________________ ________________ ________________

List all medications you take: (including over the counter medications, vitamins and supplements)

[None] ________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

List all eye drops you take: (including artificial tears and over-the-counter drops)

[None] ________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

List all major illnesses and injuries: (diabetes, hypertension, thyroid, asthma, heart disease, cholesterol)

[None] ________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

List all past surgeries: **[None]** ________________ ________________

________________ ________________ ________________ ________________

List all hospitalizations (past 3 yrs): **[None]** ________________ ________________

________________ ________________ ________________ ________________

If applicable, are you pregnant? No Yes :_______ Months

Have you had any of these eye conditions in the past: (circle) [None]

Glaucoma Cataract Crossed eyes Lazy eye Eye injury

Bulging eyes Retinal problems Eye infections Droopy eyelid

Other:________________________

Do you wear glasses? No Yes: **How old is your present pair of glasses?** __________

Do you wear contacts? No Yes: **What type?** Hard Soft: **Brand?** ______________

FAMILY HISTORY

Among your blood relatives, is there a history of any of the following? (circle) [None]

Glaucoma Lazy Eye Macular Disease Unexplained Vision Loss Eye Surgery

Cataracts Diabetes Retinal Disease Night/Color Blindness Bleeding Disorder

Other:____________________________

SOCIAL HISTORY

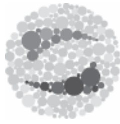
Do you use tobacco products?……………………... No Yes (how long)________________

Do you drink alcohol?……………………………….…. No Yes (amount) ________________

Do you use illegal drugs?…………………………...… No Yes (amount) ________________

Have you been exposed to or infected with HIV?… No Yes (how long ago) ____________

[PLEASE TURN OVER FOR QUESTIONS ON BACK OF SHEET]



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REVIEW OF SYSTEMS

Do you **currently** have any problems in the following areas? If "yes" then please provide information.

		No	***Yes***	***Additional Details***
Constitutional:	Fever/Chills.....	[_]	[_]	______
	Weight Loss/Gain.....	[_]	[_]	______
Skin:	Rash.....	[_]	[_]	______
Neurologic:	Headaches.....	[_]	[_]	______
Eyes:	Loss of vision.....	[_]	[_]	______
	Blurred/Distorted vision	[_]	[_]	______
	Double vision.....	[_]	[_]	______
	Dryness.....	[_]	[_]	______
	Redness.....	[_]	[_]	______
	Itching.....	[_]	[_]	______
	Burning.....	[_]	[_]	______
	Foreign body sensation.....	[_]	[_]	______
	Excess tearing/watering.....	[_]	[_]	______
	Mucous discharge.....	[_]	[_]	______
	Glare/Light sensitivity.....	[_]	[_]	______
	Eye pain or soreness.....	[_]	[_]	______
	Chronic eyelid infection.....	[_]	[_]	______
Ears, Nose, Mouth, Throat:		***No***	***Yes***	
	Allergies/Hayfever.....	[_]	[_]	______
	Sinus congestion.....	[_]	[_]	______
	Dry throat/mouth.....	[_]	[_]	______
Respiratory:	Asthma.....	[_]	[_]	______
	Emphysema/Bronchitis.....	[_]	[_]	______
Cardiovascular:	Chest pain.....	[_]	[_]	______
	Irregular heart beat.....	[_]	[_]	______
GI:	Stomach pain.....	[_]	[_]	______
	Diarrhea/Constipation.....	[_]	[_]	______
Genitouriniary:		***No***	***Yes***	
	Genitals/Kidney/Bladder.....	[_]	[_]	______
Bones, joints, muscles:				
	Joint pain.....	[_]	[_]	______
Endocrine:	Diabetes.....	[_]	[_]	______
	High or low thyroid.....	[_]	[_]	______
Psychiatric:		[_]	[_]	______

Thank you very much for taking the time to fill out this lengthy health history questionnaire. Our mission is to provide our patients with the most compassionate and highest quality healthcare possible and this information helps us in developing the best treatment plan for you.

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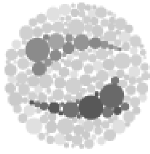

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I understand this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the Reception Desk, and that I will be offered a copy if there are any changes to the Notice of Privacy Practices.

For questions or concerns, please contact: Privacy Officer, 650-697-3200

In summary, this Notice:

1) Outlines to whom we may legally disclose your health information, including your health insurance plan so we may obtain payment for services on your behalf
2) States that we will not disclose your health information in any other way without your written authorization
3) Outlines your rights as a patient, including the
   - right to limit what information is disclosed
   - right to request confidential communication
   - right to inspect and copy your records
   - right to amend your records
   - right to receive a copy of the "Notice of Privacy Practices"
4) Gives us the permission to change our "Notice of Privacy Practices" at any time in the future, at which point you will be notified again
5) Informs you how to handle a complaint if you feel your privacy has been violated

Your signature on the form simply acknowledges that you understand our privacy practices.

Signed: _________________________________ Date:__________________

Print Name:______________________________

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient

Name of Patient: ___________________________________

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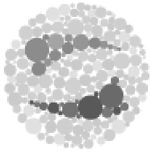

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HIPAA Authorization Release of Information

Peninsula Ophthalmology Group has taken measures to protect all of our patient's private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Portability and Accountability Act) does allow us to release information to certain outside entities on your behalf. For example, another medical office when making an appointment, your insurance company when trying to get your claim paid, your pharmacy or hospital. **Otherwise by law, Peninsula Ophthalmology Group is not permitted to release any medical information except to those individuals authorized by you.**

SELECT ONE OPTION BELOW:

[_] **I am authorizing** the person/people listed below to obtain medical information about myself. I understand that Peninsula Ophthalmology Group, is not responsible for the information provided as long as it is given to the a person that I have listed below.

Relation/Date of Birth are needed so that our office can verify that we are speaking to the correct person

Name: ______________________________ Relation: ______________ Date of birth: _______________

Name: ______________________________ Relation: ______________ Date of birth: _______________

Name: ______________________________ Relation: ______________ Date of birth: _______________

Name: ______________________________ Relation: ______________ Date of birth: _______________

[_] I **DO NOT authorize** Peninsula Ophthalmology to release **ANY** of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Signature: _____________________________ Date: __________________

Print Name: ____________________________

If not signed by the patient, please indicate relationship:
parent or guardian of minor patient
guardian or conservator of an incompetent patient

Name of Patient: __________________________________

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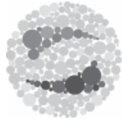

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

We are pleased to be able to provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request appointments online
- Confirm appointments via email or text message
- Receive text message appointment reminders
- Refer your patients online
- Receive notices of special events or promotions
- Submit patient satisfaction surveys

You may opt out of communications at any time by clicking the unsubscribe link in the footer of each email or by replying to a text message with 'STOP'. Standard text messaging rates apply.

We do not publish or share this information with any third parties except as required by law.

Please verify your contact information

Name ____

Cell Phone: (______)____________________

___ Initial here to opt out from text messages

Email: ____

___ Initial here for opt out from email

Please sign below that you agree to allow us to use this information in providing you these additional services.

__________________________________ _____________

Signature Date

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