



Patient Registration

Name: _____ Title (Mr. Ms. Mrs. Dr.): _____
 Address: _____
 City: _____ Zip: _____
 Phone: Home: _____ Cell: _____
 Work: _____
 Email: _____
 Date of Birth: _____ Social Security # _____
 Sex (circle): M or F
 Referred by: _____
 Primary Care (Internist) Doctor Name: _____
 Address of Primary Care Doctor: _____
 Phone Number of Primary Care Doctor: _____

Insurance Information

Please provide your insurance card for our office to photocopy for your records.

Primary Insurance: _____
 Policy #: _____ Group #: _____
 Subscriber (if other than the patient): _____
 Relationship: _____
 Secondary Insurance: _____
 Policy #: _____ Group #: _____

Welcome to Eye Center of La Jolla Comprehensive Ophthalmic Medical, Surgical, and Laser Services

Insurance and Referrals

The office policy is that payment is due at the time of service unless you have insurance with a company in which the doctor is a participating provider. If your insurance requires a copayment, the full amount is due at the time of your visit. If your insurance requires a referral or prior authorization, it is your responsibility to obtain the referral with an authorization number, prior to seeing the specialist.

Refraction Charge

Most insurances (including Medicare) do not pay for refraction (the measurement for eyeglasses/contact lens prescription). If you choose to have a measurement for glasses, there will be an additional fee of **\$50.00** at the time of your office visit in addition to your co-pay.

I have read these policies and I accept these terms.

Signature: _____ Date: _____



Medical History Questionnaire

Patient Name: _____

Date of last eye exam: _____

Review of Systems

Do you have any problems in the following areas? If yes please explain

	No	Yes
Eyes		
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>
Sandy Feeling	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Excess tearing	<input type="checkbox"/>	<input type="checkbox"/>
Occasional tearing	<input type="checkbox"/>	<input type="checkbox"/>
Itching tearing	<input type="checkbox"/>	<input type="checkbox"/>
Glare/ Lighting sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain/ soreness	<input type="checkbox"/>	<input type="checkbox"/>
Styes	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infection	<input type="checkbox"/>	<input type="checkbox"/>
Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth, Throat		
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular (heart blood vessels)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal (stomach vessels)	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary (genitals kidney bladder)	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal		
Muscle	<input type="checkbox"/>	<input type="checkbox"/>
Joint	<input type="checkbox"/>	<input type="checkbox"/>



Integumentary (skin and or breast)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine (thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic/Lymphatic		
Blood	<input type="checkbox"/>	<input type="checkbox"/>
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/ Immunologic		
Head allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Social History		
Do you drive?	<input type="checkbox"/>	<input type="checkbox"/>
Do you visual difficulty while driving?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with night driving?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how long have you had the current prescription? _____		
Have you ever worn contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been exposed to or have a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____		
Family History		
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>



PATIENT CONSENT FORM

The department of Health and Human Services has established a ‘Privacy Rule’ to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for a certain health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As a patient of Eye Center of La Jolla, we want you to know that we respect the privacy of your personal health information and will do all we can to secure and protect that privacy. Our center strives to always take reasonable precautions to protect your privacy. Only, when it is appropriate and necessary, we will provide the minimum necessary information to those who are in need of your health care information and /or information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

Eye Center of La Jolla supports full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients,) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing to the attention of our Privacy Officer. Under this law, we have the right to refuse to treat you should you refuse to disclose your personal health information. If you chose to give consent in this document, at some future time you may request to refuse all of part of your personal health information be disclosed to others. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Privacy Officer or Dr. Alborzian. You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____
Print Name: _____ Telephone: _____

If not signed by patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient