

**BERKELEY EYE CENTER**

Date: \_\_\_\_\_

Account #: \_\_\_\_\_

Mr. Mrs. Ms. Miss Dr.

Patient's Name: \_\_\_\_\_

Last

First

MI

Address

Email

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Primary Care Dr.: \_\_\_\_\_

Sex: M F Marital Status:  Single  Divorced  Married  Widowed

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Driver's Lic #: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_

How did you hear about us?  Friend/Family  Radio  Internet  Health Fair  
 Insurance  Doctor \_\_\_\_\_  Other \_\_\_\_\_

Emergency Contact Not Living With You: \_\_\_\_\_ Phone #: \_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT** (Check One)  Self  Parent  Guardian

If other than patient, please complete the following: Telephone # H \_\_\_\_\_ W \_\_\_\_\_

Name \_\_\_\_\_  
First MI Last

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M F Social Security # \_\_\_\_\_

**Insurance: Please list the subscriber of the policy, if other than the patient. List your primary insurance company first.**

PRIMARY 1. \_\_\_\_\_ ID #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Group or Policy #: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M F

SECONDARY 2. \_\_\_\_\_ ID #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Group or Policy #: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: M F

We value the opportunity to communicate with our patients via e-mail regarding appointment reminders, Berkeley Eye Center services, special offers and the latest advances in the care of your vision. **Be assured Berkeley Eye Center will not share your information with outside sources.**

I hereby consent to a health examination, related diagnostic procedures and treatments provided by the Eye Center. I hereby authorize my insurance company(s) to remit directly to the Eye Center all payment of benefits otherwise payable to me under the provision of my policy(s). I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to the Eye Center for any services provided to me. I hereby authorize the release of this information needed to determine benefits payable for related services. I also authorize the use of any photographs or data collections taken to document my ocular condition for routine care or use in research and professional publication. Photostatic copies of this authorization will be considered valid as the original.

**If my insurance company requires referrals, vouchers or authorizations, I will present these to the receptionist immediately. Failure to do so will make me responsible for full payment once services are rendered.**

Signature \_\_\_\_\_

(Please circle one)      Patient      Parent      Legal Guardian      Responsible Party

\_\_\_\_\_ **I have received a copy of the “Notices of Privacy Practices”**

**initial**

# Berkeley Eye Center GENERAL HISTORY

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Sex:** Male / Female

**1. Allergies:** \_\_\_\_\_

**2. History of following diseases (check if YES):**

Self	Family
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Self	Family
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**Cardiac**

1. Heart disease
2. High blood pressure
3. Chest pain


**Respiratory**

1. Asthma
2. Bronchitis
3. Emphysema
4. Oxygen dependence


**Neurological**

1. Stroke
2. Seizures


**Kidney**

1. Renal insufficiency/failure
2. Dialysis dependence


**Endocrine**

1. Diabetes (Type: \_\_\_\_\_)
2. Thyroid problems


**Musculoskeletal**

1. Walker/wheelchair use
2. Joint pain (Location: \_\_\_\_\_)


**Gastrointestinal**

1. Gastro-esophageal reflux
2. Hiatal hernia
3. Hepatitis (Type: \_\_\_\_\_)


**Eye disease**

1. Cataracts
2. Glaucoma
3. Macular degeneration
4. Retinal detachment


**Ear/Nose/Throat**

1. Chronic cough
2. Hearing aid use


**Psychiatric**

1. Depression
2. Anxiety


**Other**

1. Cancer (Type: \_\_\_\_\_)
2. HIV
3. Bleeding disorders (Type: \_\_\_\_\_)
4. \_\_\_\_\_
5. \_\_\_\_\_


**3. Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**4. Previous surgeries:** \_\_\_\_\_

\_\_\_\_\_

**5. Tobacco use:** Yes / No      Quantity: \_\_\_\_\_      If you quit, how long ago? \_\_\_\_\_

**6. Alcohol consumption?** Yes / No      Quantity: \_\_\_\_\_

**7. Drug abuse?** Yes / No      Type: \_\_\_\_\_

**8. If you are female, possibility of pregnancy?** Yes / No

**9. Do you have an Advanced Directive for Healthcare (Living Will)?** Yes / No

**10. Do you suffer from any of the following?**

Blurry vision _____	Sinus problems _____	Flashes of light _____
Dry eyes _____	Headaches _____	Halos _____
Watery eyes _____	Pain in your eyes _____	Floaters _____
Seasonal Allergies _____	Dizziness _____	Other _____

**11. Do you wear glasses or contact lenses?** Yes / No      **If yes:** Extended      Daily      Hard      Soft

**SIGNATURE:** \_\_\_\_\_