

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
------	--------

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: _____

BERKELEY EYE CENTER

REFRACTIVE PATIENT QUESTIONNAIRE

Patient Name: _____ **Date:** _____ **DOB:** _____ **Sex: Male/Female**

Allergies: _____

Please answer the following questions:

1. Have you ever been diagnosed with:

- | | | |
|----------------------------------|-----|----|
| a. KERATOCONUS? | Yes | No |
| b. OCULAR HERPES? | Yes | No |
| c. FUCH'S ENDOTHELIAL DYSTROPHY? | Yes | No |
| d. CORNEAL SCARS? | Yes | No |
| e. DIABETES? Type: _____ | Yes | No |

If yes, is it CONTROLLED?

- | | | |
|-------------------------------|-----|----|
| f. RHEUMATOID ARTHRITIS? | Yes | No |
| g. LUPUS? | Yes | No |
| h. COLLAGEN VASCULAR DISEASE? | Yes | No |

2. Have you ever experienced DRY EYES? Yes No

3. Does your VISION FLUCTUATE? Yes No

4. Is there a possibility that you might be PREGNANT? Yes No

5. Are you LACTATING? Yes No

6. Have you taken either of the following medications:

- | | | |
|---------------|-----|----|
| a. AMIODARONE | Yes | No |
| b. ACTUTANE | Yes | No |

If yes, when was the last time you took the medication? _____

Signature: _____

Date: _____