Inland Valley Retina

Medical History Questionnaire / *Cuestionario Médico*

Name/ *Nombre*_____ Date/ *Fecha*: _____

Date of Birth: _____ Date of **Last Eye Exam:**_____
Fecha de Nacimiento *Fecha de último examen visual*

Chief Visual Complaint: What is your main visual complaint and how long have you had it?
¿Cuál es su principal reclamo visual y por cuánto tiempo lo ha tenido?

_____

List **Trauma** affecting head or eyes:_____
Lista de los traumas a la cabeza o los ojos

Do you currently have any problems in the following areas?
¿Tiene actualmente algún problema en las siguientes áreas?

Eyes ***Ojos***	Yes *Si*	No	Explanation *Explicación*	**Family History pertaining to eyes** ***Antecedentes familiares relativos a los ojos***	Yes *Si*	No
Loss of vision *Pérdida de vision*				Glaucoma *Glaucoma*		
Blurred vision *Visión borrosa*				Macular Degeneration *Degeneración Macular*		
Fluctuating vision *Fluctuación de la visión*				Myopia *Myopia*		
Distorted vision *Visión distorsionada*				Unexplained poor vision *Mala visión inexplicable*		
Loss of side (peripheral) vision *Perdida de la visión de un lado*				Cataract *Cataratas*		
Double vision *Visión doble*				Night blindness *Ceguera nocturna*		
Eye pain *Dolor de ojo*						
Excess tearing *Ojos llorosos/lagrimeo*						
Light sensitivity *Sensibilidad a la luz*						
Redness *Enrojecimiento*						
Itching *Comezón*						
Discharge *Secreción ocular*						
Poor night vision *Mala visión nocturna*						
Curtain effect *Efecto de cortina*						
Flashing lights *Destellos de luz*						
Floaters *Flotadores*						
Other eye conditions *Otros trastornos oculares*						

Past Medical History ***Historial Médico***	Yes *Si*	No	How long?/Comments *Desde Cuando? Comentarios*	**Personal Habits** ***Hábitos personales***	Yes *Si*	No
Hypertension *Hipertensión*				Alcohol *Alcohol*		
Anemia or Blood Disorder *Anemia o desorden de la sangre*				Smoking *Fumar*		
Heart Disease *Enfermedades del Corazón*				Recreational Drugs *Drogas recreativas*		
Diabetes *Diabetes*				Occupational Hazards *Riesgos Laborales*		
Cancer *Cáncer*						
Cholesterol *Colesterol*						
Drug abuse history *Historia de abuso de drogas*						
Tuberculosis *Tuberculosis*						
Stroke *Infarto*						
Thyroid Disease *Enfermedad de la tiroides*						
Inherited Diseases *Enfermedades hereditarias*						

Do You have **Allergies** to medications? [ ] Yes [ ] No
¿Es alérgico(a) a algún medicamento?

If Yes, List the medications: _____
Si es alérgico(a), a cual medicina

List Medications presently taking: _____
¿Cuáles medicamentos toma?

List Major Eye Surgeries: _____
Lista de cirugías de ojos

Inland Valley Retina

Medical Associates, Inc.

Paul A. Blacharski, M.D., Theodore K. Lin, M.D.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, and/or Healthcare Operations

I, _____, understand that as part of my health care, Inland Valley Retina originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Inland Valley Retina is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Inland Valley Retina reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Inland Valley Retina change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept / decline** the terms of this consent.

_____ _____

Patient Signature / Legal Guardian Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS/DESIGNATED INDIVIDUALS

In accordance with federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of the practice to discuss your condition with members of your family or other individuals you designate, we must obtain your authorization prior to doing so. In the event of a critical episode of if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____***NO***, I do not authorize Inland Valley Retina to verbally release any or all information concerning my medical care on any personal answering machine/voice mail.

_____***YES***, I authorize Inland Valley Retina to verbally release any or all information concerning my medical care on my personal answering machine/voice mail, and/or any of the phone numbers I provided on my Registration form.

_____***NO***, I do not authorize Inland Valley Retina to release any or all medical information concerning my medical care to anyone other than myself.

_____***YES***, I authorize Inland Valley Retina to verbally release any or all information concerning my medical care to only those ***individuals I have listed below*****.**

_____ _____

Name Relationship to patient

_____ _____

Name Relationship to patient

X_____ _____

Patient Signature / Legal Guardian Date

_____ _____

Witness Signature Date

Inland Valley Retina

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RECORDS RELEASE AUTHORIZATION

Patient: _____ Birthdate: _____

Address: _____

This is to request and authorize:

_____

(Name of Doctor or facility authorized to release information)

_____

Street Address City State Zip Code

To release the following information to:

_____

(Name of Doctor or facility authorized to release information)

_____

Street Address City State Zip Code

Check records to be released

_____ All Medical records
_____ Fluorescein angiogram/Photos
_____ Other _____
_____ Operative reports
_____ Ultrasound

This authorization is valid until: _____

I realize that I am entitled to a copy of this authorization

_____ _____ _____

(Signature of patient or responsible party) (Relationship) Date

Witness: _____

1810 Fullerton Ave., Ste 206
Corona, CA 92881

29798 Haun Rd., Ste 200
Menifee, CA 92586

41900 Winchester Rd., Ste 201
Temecula, CA 92590

Phone: (951) 679-0400 FAX: (951) 672-6667

Inland Valley Retina

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MRN _____

Patient Information

Patient _____ Date of Birth /____/____
Last First Middle

Home Address **or** Nursing Facility
Address _____

City _____ State _____ Zip Code _____

Telephone (____) _____ Cell Phone(____) _____ E-mail _____

Marital Status _____ Gender _____Drivers Lic. # _____Social Security # ___-___-___

Employer _____ Occupation _____

Employer Address _____ Telephone (____) _____

Spouse, Parent, or Responsible Party (Circle One)

Name _____ Social Security # ___-___-___

Address _____ Drivers Lic. # _____

Employer _____ Occupation _____

Address _____ Telephone _____

In Case of Emergency

Name_____Relationship_____

Address_____ Telephone (____) _____

Nearest Relative (Not living with you)

Name_____Relationship_____

Address_____ Telephone (____) _____

Accident Industrial/Work related? Yes r No r Non-Work related: Auto? Yes r No r
Did you come through the Emergency Room? Yes r No r Other? Yes r No r

Date of Injury_____ Has employer been notified?_____ Has carrier been notified?_____

Industrial Insurance_____ Policy #_____

Address_____ Telephone_____

1810 Fullerton Avenue, Ste 206
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29798 Haun Road, Ste 200
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Medical Associates, Inc.

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Primary Care Doctors

Family Physician: Name_____ Telephone (____)_____

Address_____

Optometrist/ Ophthalmologist: Name_____ Telephone (____)_____

Address_____

Medical Insurance Information

(1) Primary:

Insurance Company_____ Group #_____

Policy Holder_____ Policy/Member I.D. #_____

Date of Birth_____ Sex_____ Patient Relationship to Policy Holder_____

Referring Physician_____ Referring Medical Group_____

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(2) Secondary: ❑ MEDIGAP ❑ Employer Retiree ❑ Employer Secondary

Insurance Company_____ Group #_____

Policy Holder_____ Policy/Member I.D. #_____

Date of Birth_____ Sex_____ Patient Relationship to Policy Holder_____

Referring Physician_____ Referring Medical Group_____

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(3) Tertiary: ❑ MEDIGAP ❑ Employer Retiree ❑ Employer Secondary

Insurance Company_____ Group #_____

Policy Holder_____ Policy/Member I.D. #_____

Date of Birth_____ Sex_____ Patient Relationship to Policy Holder_____

Referring Physician_____ Referring Medical Group_____

I understand that dilating drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effects of the medicine have worn off or that I feel safe in driving. The effects of the drops may last an hour or longer.

Signature_____ Date _____

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FINANCIAL RESPONSIBILITY AGREEMENT

I understand I am financially responsible to **Inland Valley Retina** for any charges incurred and not paid for by my insurance company/companies. I understand that it is my responsibility to pay **Inland Valley Retina** for any deductible, co-payments, and balances not paid for by my insurance company/companies. I understand that co-payments and deductibles are due at time of visit or procedure. I understand that if I am a member of a Health Maintenance Organization (HMO), I am responsible for obtaining prior authorization from my Primary Care Physician for all visits and procedures performed in our offices. I understand that if prior authorization is not obtained, I may be financially responsible for the charges incurred on that particular date of treatment.

A $25 charge will be added to your account for broken appointments unless a 24 hr notice is given

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

TO MY INSURANCE CARRIER(S):

1. I authorize the release of any medical information necessary to process my insurance claim(s).
2. I authorize and request payment of medical benefits directly to my physicians.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoke by me.
4. I agree that a photocopy of this form may be used in lieu of the original.

Signed (patient or representative)_____ Date _____

Print Name _____

Signed (insured if other that patient)_____ Date _____

MRN _____

Birthdate _____

In compliance with the HITECH Act (EHR) to attain Meaningful Use we are required to capture demographic data including your race, ethnicity and preferred language. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below.

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Patient Name: _____ Date: _____

Race:
___African American
___Arabic
___Asian
___Caucasian
___Filipino
___Hispanic
___Other_____

Ethnicity:
___Hispanic
___Non-Hispanic

Primary Language:
___Arabic
___Chinese
___English
___French
___Korean
___Spanish
___Other_____

Prefer Not To Answer: _____

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