PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date_____

Patient name _____ Patient #_____
FIRST MI LAST

SSN_____ ☐ Male ☐ Female Birthdate_____ Home phone _____

Address_____

City_____ State_____ Zip_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parent's employer _____ Work phone _____

Business address _____ City _____ State_____ Zip_____

Spouse or parent's name _____ Employer_____ Work Phone _____

If patient is a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's License #_____ Birthdate_____ Financial institution _____

Employer_____ Work phone _____

Is this person currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of insured _____ Relationship to patient_____

Birthdate_____ Social Security Number _____ Date employed_____

Name of employer _____ Work Phone _____

Address of employer_____ City _____ State_____ Zip_____

Insurance company _____ Group #_____ Union or local #_____

Insurance co. address_____ City _____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient_____

Birthdate_____ Social Security Number _____ Date employed_____

Name of employer _____ Work Phone _____

Address of employer_____ City _____ State_____ Zip_____

Insurance company _____ Group #_____ Union or local #_____

Insurance co. address_____ City _____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

AUTHORIZATION & RELEASE

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____

Signature of patient (or parent if minor) Date

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date: _____

Address_____ Home Phone _____

City/State/Zip:_____ Work Phone _____ Cell Phone_____

Primary Care Physician's Name: _____ Dr.'s Phone: _____

PATIENT'S MEDICAL HISTORY

List any medications you are taking (including oral contraceptives, aspirin, over-the-counter medications and home remedies)_____

_____

Do you have any allergies to medications: ❑ Yes ❑ No If yes, please list:_____

_____

List all major injuries, surgeries and/or hospitalizations you have had:_____

_____

For Women: Are you pregnant and/or nursing? ❑ Yes ❑ No

Have you had any of the following eye conditions?

	Yes	No
Macular Degeneration	❑	❑
Glaucoma	❑	❑
Strabismus (Crossed Eyes)	❑	❑
Refractive Surgery (LASIK/RK)	❑	❑
Eye Injury	❑	❑
Drooping Eyelid	❑	❑
Cataracts	❑	❑
Cataract Surgery	❑	❑
Amblyopia (Lazy Eye)	❑	❑
Eye Infection	❑	❑
Retina Disease	❑	❑
Retina Surgery	❑	❑
Diabetic Retinopathy	❑	❑
Other_____		

	Yes	No
Loss of Vision	❑	❑
Blurred Vision	❑	❑
Tired Eyes	❑	❑
Distorted Vision/Haloes	❑	❑
Double Vision	❑	❑
Dryness	❑	❑
Mucous Discharge	❑	❑
Redness	❑	❑
Sandy or Gritty Feeling	❑	❑
Itching	❑	❑
Burning	❑	❑
Excess Tearing/Watering	❑	❑
Glare/Light Sensitivity	❑	❑
Eye Pain/Soreness	❑	❑
Styes or Chalazion	❑	❑
Flashes/Floaters in Vision	❑	❑

Do you currently, or have you ever had any problems in the following areas?

Constitutional	Yes	No
Fever, weight loss/gain	❑	❑
Integumentary		
Skin Conditions	❑	❑
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
Endocrine		
Thyroid/Other Glands	❑	❑
Psychiatric		
Depression	❑	❑
Anxiety	❑	❑
Attention Deficit	❑	❑
Bones/Joints/Muscles		
Rheumatoid Arthritis	❑	❑
Other Arthritis	❑	❑
Lymphatic/Hematologic		
Anemia	❑	❑
Bleeding Problems	❑	❑

Ears, Nose, Mouth, Throat	Yes	No
Allergies/Hay Fever	❑	❑
Sinus Congestion	❑	❑
Runny Nose/Post Nasal Drip	❑	❑
Chronic Cough	❑	❑
Dry Throat/Mouth	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Vascular/Cardiovascular		
Diabetes	❑	❑
Heart Condition	❑	❑
High Blood Pressure	❑	❑
Vascular Disease	❑	❑
Gastrointestinal		
Diarrhea/Constipation	❑	❑
Genitourinary		
Genitals/Kidney/Bladder	❑	❑

Other, please list_____

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer:* ❑ **YES,** *I would prefer to discuss my Social History information directly with my doctor (check box).*

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulty when driving? ❑ Yes ❑ No

Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/how long _____

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long _____

Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long _____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

FAMILY HISTORY *(Please note any family history: parents, grandparents, siblings, children, living or deceased)*

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment/Disease	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Thyroid Disease	☐	☐	_____
Other	☐	☐	_____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorized my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Anna M. Torres, O.D. for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Lifetime Patient Signature _____ Date _____

RELEASE OF EXAMINATION FINDINGS

I authorize Dr. Torres to send a report of my examination to my physician, referring doctor and/or referring Health Professional

Patient Signature _____ Date _____

I authorize Dr. Torres to discuss the results of my examination to the following individuals. (Please be sure to list spouse, parents, sons/daughters, caregivers etc.)

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature _____ Date _____

RECEIPT OF PATIENT CONFIDENTIALITY POLICY

I have received Dr. Torres patient confidentiality policy.

Patient Signature _____ Date _____

Vision Care

ANNA M. TORRES, O.D.

1420 N. Claremont Blvd., Ste. 209-B • Claremont, CA 91711
(909) 621-0057 • Fax: (909) 621-5485

Important Information Regarding Insurance Claims

We are pleased to assist you by filing the initial insurance claim with your insurance carrier. However, it is the patients/parents responsibility to provide all insurance information prior to services being rendered. Any changes in coverage should also be provided prior to services rendered. Failure to do so will make it the patients/parents responsibility to collect from his/her own insurance carrier. (____)

It is our policy to allow 45 days for your carrier to pay the claim. If the claim has not been paid, payment from you will be expected. If you have not received an explanation of benefits from your carrier within 45 days, please contact them directly to determine why your claim has not been paid.

The insurance is a contact between you, your employer or other group, and the insurance company. Coverage by the same company varies from one group to another so we cannot always determine your level of benefits in advance. Employers change their level of coverage and change plans so your coverage may have changed significantly since your last visit. The personnel office or insurance agent is your best source for current coverage. Insurance companies are also bought, sold, and merged. We may not often be informed of these changes until a claim is filed.

All co-payments and/or material overages are due at the time of service. An authorization from your insurance company for services and/or materials does not constitute a guarantee of payment by the insurance company. All charges incurred are ultimately the patients/parents responsibility.

We appreciate your assistance in helping you gain the greatest benefit from your insurance company. Remember that your coverage is a benefit and not an entitlement.

I have read and understand the above terms.

_____ _____

Account Responsible Signature Date