

ADVANCED VISION CARE

PATIENT REGISTRATION

Samuel Masket, MD

Nicole Fram, MD

Gavin Bahadur, MD

PLEASE PRINT CLEARLY AND HAVE YOUR FORMS COMPLETED PRIOR TO ARRIVING AT THE OFFICE.

Patient's Name _____	Age _____
Home Address _____	City _____ Zip _____
Date of Birth _____	Male <input type="checkbox"/> Female <input type="checkbox"/> Cell Phone _____ Home Phone _____

Patient's Social Security # _____	Driver's License # _____
Patient Employed By _____	Occupation _____
Business Address _____	Business Phone (____) _____
Spouse Employed By _____	Occupation _____
Business Address _____	Business Phone (____) _____
EMERGENCY CONTACT _____	Phone _____
Responsible party if minor _____	_____
Address & Telephone _____	_____

MEDICAL PHYSICIAN _____	Phone # _____
MEDICAL ALLERGIES _____	
Referred by _____	_____
Insurance Type _____	Private _____ MediCare _____ MediCal _____ VSP _____ Mesa _____
Ins. Name _____	Policy _____ Group # _____

All professional services rendered are charged to the patient. I understand that I am financially responsible for all charges whether or not covered by insurance.	
Date _____	Signed _____

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Permission to discuss Medical care: I hereby give Advanced Vision Care (AVC) permission to discuss and answer any questions regarding my medical care/condition to: (This must include translators)

Name: _____

Relationship: _____ Phone # _____

Your Signature: _____ Date: _____

Assignment of Benefits & Confidentiality:

Assignment of Insurance benefits: I hereby authorize direct payments to Advanced Vision Care (AVC) for services rendered under their supervision. I understand that I am financially responsible for any balance unpaid or not covered by my insurance.

Authorization to release information: I hereby authorize AVC to release any medical or incidental information that may be required for either medical care or in processing application for financial benefit.

Medicare: I certify that the information given by me is correct. I authorize release of all medical records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

Protected Health Information:

Advanced Vision Care Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You also have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that:

- My protected health information may be disclosed or used for treatment, payment or health care operations.
- I have the right to review AVC's "Notice of Privacy Practices".
- AVC has the right to change their policies.
- I have the right to restrict the use of my information but AVC does not have to agree to those restrictions.
- I may revoke this consent in writing at any time and all future disclosures will then cease.
- AVC may condition treatment upon the execution of this consent.

Signature of Patient or representative

Date: _____

Relationship if other than patient

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CONSENT FOR TREATMENT

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I HEREBY AUTHORIZE Advanced Vision Care to examine and treat me, or the individual for whom I am responsible. During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare.

I authorize Advanced Vision Care to release information acquired in the course of my examination and treatment to my insurance carriers.
I further understand that I have primary responsibility for payment of my charges.

X _____

Signature of Patient (or guardian)

FOR OUR MEDICARE PATIENTS

After you are seen by the doctor, Advanced Vision Care will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on all Medicare forms submitted for you by our office.

X _____

Signature of Medicare Beneficiary

ADVANCED VISION CARE MEDICAL HISTORY QUESTIONNAIRE

Name:

Primary reason for today's (first) visit:

REVIEW OF SYSTEMS:

Do you presently have any problems in the following areas? If "YES", give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[]	[]	_____
Loss of side vision, double vision	[]	[]	_____
Itching, burning, or discharge	[]	[]	_____
Redness	[]	[]	_____
Gritty feeling, dryness or tearing	[]	[]	_____
Glare/light sensitivity, or halos	[]	[]	_____
Eye pain or soreness	[]	[]	_____
Infection of eye lashes or lid, styes	[]	[]	_____
Ears, nose, mouth, throat			
Cardiovascular (heart, blood vessels)			
Respiratory (lungs/breathing)			
Gastrointestinal (stomach/intestines)			
Genitourinary (genitals/kidney/bladder)			
Musculoskeletal (muscles/joints)			
Integument (skin/breast)			
Neurological			
Psychiatric			
Endocrine (diabetes, thyroid, glands)			
Hematologic/Immune (blood disorder)			
Seasonal allergies (hay fever, etc.)			

PAST HISTORY (EYE)

YES NO

Have you **EVER** used **FLOMAX** [] [] _____
 or **Tamsulosin**
 Eye drops currently in use: (list)

YES NO

Allergies to eye drops [] [] _____
 History of cataract, glaucoma [] [] _____
 History of cross/lazy eye [] [] _____
 Eye injury or other disease [] [] _____
 Eye surgery [] [] _____

PAST HISTORY (MEDICAL)

Do you have any **MEDICATION ALLERGIES**? [] NO [] YES Penicillin Sulfa

Do you have problems with **anesthesia**? [] NO [] YES

List any **systemic medications** (other than eyedrops) that you are currently using:

List all major illnesses: Diabetes ____ Hypertension ____
Other:

List any major surgical procedures:

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCULAR			
Blindness	[]	[]	_____
Cataract	[]	[]	_____
Glaucoma	[]	[]	_____
Macular degeneration	[]	[]	_____
Retinal detachment	[]	[]	_____
MEDICAL			
Diabetes	[]	[]	_____
Hypertension	[]	[]	_____
Heart Disease	[]	[]	_____
Stroke	[]	[]	_____
Arthritis, lupus, etc	[]	[]	_____
Other (list)	[]	[]	_____

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Do you drive?	[]	[]	_____
Do you drive at night?	[]	[]	_____
Do you wear contact lenses?	[]	[]	_____
My vision causes problems with:			
*Driving			
*Night vision			
*Reading			
*Sports/Outdoor activities			

Current Occupation _____

	YES	NO	
Do you drink alcohol?	[]	[]	How much per day? _____
Do you smoke?	[]	[]	How much per day? _____

Patient's signature: _____ **Date:** _____

Physician's signature: _____ **Date:** _____

History reviewed [] No changes [] Additions as noted

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GENERAL EYE QUESTIONNAIRE

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VISUALFUNCTIONING

Always

Sometimes

Never

Don't Know

Does your sight make it a problem for you to:

Read newspapers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read a telephone book	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See traffic signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read labels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read price tags	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognize people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See cracks in the sidewalk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watch TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work at your job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoy recreation and leisure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SYMPTOMS

Always

Sometimes

Never

Don't Know

Have you been bothered by:

Poor night vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing rings around lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hazy vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing in dim light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DRIVING AND ACCIDENTS

Do you drive? Yes No

Are you currently able to drive: **Always** **Sometimes** **Never** **Don't Know**

During daylight hours

During evening/night hours

Do problems with your sight cause you to be fearful when you drive? **Always** **Sometimes** **Never** **Don't Know**

During daylight hours

During evening/night hours

During the past six months, have you made any driving errors? **Always** **Sometimes** **Never** **Don't Know**

CURRENT VISION

How is your vision with your glasses or contacts now?

Excellent Good Fair Poor Very Poor

SATISFACTION WITH CARE

How satisfied are you with your ophthalmic medical treatment?

Excellent Good Fair Poor Very Poor

ACTIVITIES AND DAILY LIFE

Are you usually able to : **Always** **Sometimes** **Never** **Don't Know**

Get around in your own home

Get around in your own neighborhood

Shop for groceries

NAME _____ **SIGNATURE:** _____ **DATE:** _____