ADVANCED VISION CARE

PATIENT REGISTRATION

Samuel Masket, MD **Nicole Fram, MD** **Juliet Chung, MD**

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

Patient's Name ______ Age ______

Home Address ______ City ______ Zip ______

Date of Birth ______ Male ☐ Female ☐ 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 ______

ADVANCED VISION CARE

Samuel Masket, MD   Nicole Fram, MD   Juliet Chung, MD

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.**

____   **Date:** _________

Signature of Patient or representative

____

Relationship if other than patient

ADVANCED VISION CARE

CONSENT FOR TREATMENT

Samuel Masket, MD   Nicole Fram, MD   Juliet Chung, MD

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

GENERAL EYE QUESTIONNAIRE

Samuel Masket, MD **Nicole Fram, MD** **Juliet Chung, MD**

VISUALFUNCTIONING	**Always**	**Sometimes**	**Never**	**Don't Know**
Does your sight make it a problem for you to:				
Read newspapers	☐	☐	☐	☐
Read a telephone book	☐	☐	☐	☐
See traffic signs	☐	☐	☐	☐
Read labels	☐	☐	☐	☐
Read price tags	☐	☐	☐	☐
Recognize people	☐	☐	☐	☐
See steps	☐	☐	☐	☐
See cracks in the sidewalk	☐	☐	☐	☐
Watch TV	☐	☐	☐	☐
Work at your job	☐	☐	☐	☐
Manage your home	☐	☐	☐	☐
Enjoy recreation and leisure	☐	☐	☐	☐

SYMPTOMS

	Always	**Sometimes**	**Never**	**Don't Know**
Have you been bothered by:				
Poor night vision	☐	☐	☐	☐
Seeing rings around lights	☐	☐	☐	☐
Glare	☐	☐	☐	☐
Hazy vision	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐
Seeing in dim light	☐	☐	☐	☐

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:**___________

ADVANCED VISION CARE
MEDICAL HISTORY QUESTIONNAIRE

Samuel Masket, MD   Nicole Fram, MD   Gavin Bahadur, MD   Kenneth L Gordon, MD

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	[ ]	[ ]	______________________

ADVANCED VISION CARE
MEDICAL HISTORY QUESTIONNAIRE

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

OCULAR	YES	NO	EXPLANATION
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