Name:
DOB:

Date:

PATIENT MEDICAL HISTORY QUESTIONNAIRE

RETINA CONSULTANTS OF ORANGE COUNTY

PLEASE SELECT YES NO

Past Medical History/Review of Systems:

Cardiovascular
- ☐Y ☐N High Cholesterol
- ☐Y ☐N Heart Attack
  Date:_____
- ☐Y ☐N Angina
- ☐Y ☐N Mitral Valve Prolapse
- ☐Y ☐N Artificial Heart Valve
- ☐Y ☐N Stroke
  Date:_____
- ☐Y ☐N High Blood Pressure
  Date:_____
- ☐Y ☐N Pacemaker

Respiratory
- ☐Y ☐N Asthma
- ☐Y ☐N COPD/Emphysema

Other_____

Endocrine
- ☐Y ☐N Diabetes Type 1 or Type 2
  Insulin or Non-Insulin
  Date:_____
- ☐Y ☐N Thyroid

Skin Problems
- ☐Y ☐N Acne
- ☐Y ☐N Skin Cancer

Ear/Nose/Throat
- ☐Y ☐N Sinus Problems
- ☐Y ☐N Hearing Aids

Hematologic
- ☐Y ☐N Anemia
- ☐Y ☐N Bleed/bruise easily
- ☐Y ☐N Cancer
  Type:_____

Ocular History
- ☐Y ☐N Cataract
- ☐Y ☐N Glaucoma
- ☐Y ☐N Retinal Tear/Detachment

Other:_____

Gastrointestinal
- ☐Y ☐N Ulcers
- ☐Y ☐N Colitis
- ☐Y ☐N Diverticulitis
- ☐Y ☐N Liver/hepatitis

Genitourinary
- ☐Y ☐N Kidney
- ☐Y ☐N Bladder
- ☐Y ☐N Prostate

Musculoskeletal
- ☐Y ☐N Arthritis
- ☐Y ☐N Joint Replacement
  Date:_____

Neurologic/Psychiatric
- ☐Y ☐N Seizures
- ☐Y ☐N Parkinson's Disease
- ☐Y ☐N Alzheimer's
- ☐Y ☐N Anxiety/Depression
- ☐Y ☐N Multiple Sclerosis/MS

Other Medical Problems/Symptoms:_____

Past Surgical History: (please list any surgeries other than eyes)

_____

_____

Please list **all medications** you are currently taking:

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

Please list any **allergies** to medicines:

_____

Social History:
Smoking ☐Y ☐N (If YES: packs per day_____) (If Quit Smoking: Date:_____)
Alcohol ☐Y ☐N (If YES: occasional / 1 per day / 1 per week / Other_____)

Family History:
- ☐Y ☐N Cancer
- ☐Y ☐N Heart Disease
- ☐Y ☐N Macular Degeneration
- ☐Y ☐N Diabetes
- ☐Y ☐N Glaucoma
- ☐Y ☐N Hypertension
- ☐Y ☐N Retinal Detachment
- ☐Y ☐N Other_____

_____ Technician

_____ M.D. Signature

BC2

Name:
DOB:

Date:

NEW PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION — PLEASE COMPLETE ALL BLANKS						DATE	REFERRED BY (NAME OF PHYSICIAN OR REFERRING PARTY)
NAME - LAST			FIRST				MIDDLE INITIAL
ADDRESS-STREET				CITY			
STATE	ZIP	(AREA CODE) HOME PHONE NUMBER	(AREA CODE) CELL PHONE NUMBER		DATE OF BIRTH		AGE
SOCIAL SECURITY NUMBER		SEX	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED		SPOUSE'S NAME		
Race (Please Circle) White Asian Other **African American** Decline		Ethnicity (Please Circle) Non-Hispanic Hispanic **Decline**	Preferred Language (Please Circle) English Spanish Chinese Japanese Vietnamese Arabic Farsi Other		Smoking Status Former Current Never		
EMPLOYER		WORK STATUS	JOB DESCRIPTION		(AREA CODE)TELEPHONE NUMBER		
EMERGENCY CONTACT NAME AND PHONE NUMBER							

RESPONSIBLE PARTY

☐ SELF ☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER _____

NAME (LAST, FIRST, MIDDLE INITIAL)	(AREA CODE) TELEPHONE NUMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS (IF DIFFERENT THAN ABOVE) (STREET, CITY, STATE AND ZIP CODE)			
EMPLOYER		(AREA CODE) TELEPHONE NUMBER	

PRIMARY CARE PHYSICIAN	GENERAL OPHTHALMOLOGIST
PHYSICIAN NAME	NAME
(AREA CODE) TELEPHONE NUMBER	(AREA CODE) TELEPHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Retina Consultants of Orange County. I understand that I am financially responsible for any unpaid balances. I also authorize Retina Consultants of Orange County to release to my insurance carriers any information required to process this claim

SIGNATURE

RETINA CONSULTANTS OF ORANGE COUNTY

SCOTT GRANT, M.D.
SEAN D. ADREAN, M.D.
ASHKAN PIROUZ, M.D.
GLEN D. JARUS, M.D.
HEMA RAMKUMAR, M.D.

301 WEST BASTANCHURY ROAD #285
FULLERTON, CALIFORNIA 92835
(714) 738-4620 • FAX (714) 738-0388

3771 KATELLA AVENUE #208
LOS ALAMITOS, CALIFORNIA 90720
(562) 431-7345 • FAX (562)-431-7317

Name:
DOB:

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of said notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient Representative: _____

Signature: _____ Date: _____

PLEASE LIST ANY FAMILY MEMBERS WE CAN RELEASE YOUR MEDICAL INFORMATION TO BELOW.

X

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging receipt of the "Notice of Privacy Practices" for **Retina Consultants of Orange County, Professional Corporation**, but was unable to do so, as documented below:

Date	Reason	Name	Signature

Name:
DOB:

Date:

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I, _____, am currently an eligible member enrolled with _____ insurance or IPA. I understand that if for any reason I am not eligible under this insurance or IPA on the dates services are rendered, I (or Guardian if minor) will be held responsible for any services provided to me.

Patient or Guardian Signature: _____

Date: _____

Name:
DOB:

Date:

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Rx History Consent

I authorize Retina Consultants of Orange County to access my prescription medical history from other healthcare providers or third party pharmacy benefit payers in order to reconcile all medications with the purpose of improving patient care, patient safety, and clinic efficiency.

I authorize Retina Consultants of Orange County to obtain my medical prescription history for the duration of two years from the date undersigned.

Patient Name _____ Patient Signature _____ Date _____

Patient Preferred Pharmacy

Complete pharmacy information below to indicate which pharmacy your electronic prescriptions will be sent.

Preferred Pharmacy Name _____ Preferred Pharmacy Phone Number _____

Preferred Pharmacy Address _____