Date:_____

Please Print

Welcome To Arrowhead Eye Associates

Patient Name: _____

Date of Birth: _____ Age: _____

Marital Status: _____ Married _____ Single _____ Widowed _____ Divorced

Sex: Male _____ Female _____ Social Security # _____

Mailing Address _____

City_____ State_____ Zip Code_____

Home Phone ( ) _____ - _____ Cell Phone ( ) _____ - _____

Work Number Phone ( ) _____ - _____ E-mail Address _____

Best Method of Contact : _____ Is detailed message OK : Yes / No

Occupation _____ Employed by _____

Do you have a power of Attorney? Yes / No

Please attach copy.

Do you have an advanced directive? Yes / No

Spouse or Parent / Guardian / Conservator Information

Name_____

Date of Birth: Relationship: _____

Social Security # _____ Phone ( ) _____ - _____

Employed by _____Occupation _____

Business Address _____

City_____ State_____ Zip Code_____

Business Phone ( ) _____ - _____

Insurance Information

____ NO INSURANCE

____ Medicare ID # _____

____ Medical ID # _____

____ Other Insurance - Carrier Name _____

Policy # and Effective Date _____

Name: _____ Date: _____

Subscriber Information

☐ PATIENT ☐ OTHER

Name : _____ Relationship _____

Date of Birth: _____ Social Security # _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____

Phone ( ) _____ - _____

Requested by State of California

RACE _____

ETHNICITY _____

PRIMARY LANGUAGE _____

Medical History

Medications you are currently taking :

Name of Medication	Dosing	Reason Prescribed

Do you take **FLOMAX**? **YES** **NO**
Do you take **COUMADIN**? **YES** **NO**
Do you take **ASPIRIN** OR **IBUPROFEN**? **YES** **NO**
Do you take **NITROGLYCERIN**? **YES** **NO**
Allergies to Medications? *(please list below)* **YES** **NO**

_____

_____

Allergic to:
Adhesive tape □ Iodine □ Latex □

Pharmacy Information

Pharmacy Name : _____
Address or Location _____
Phone Number _____

Please list ANY surgeries you have had on your body :

_____

_____

_____

Do you have any history of trauma? YES NO

Explain : _____

Have you ever had a blood transfusion? YES NO

When ? _____

Is there any history of bleeding problems or reactions to anesthesia? YES NO

Explai _____

Are you pregnant? YES NO
Do you currently wear glasses? YES NO
Do you wear Contacts? YES NO
SOFT LENSES □ HARD LENSES □ GAS PREMEABLE □

. MEDICAL HISTORY

Name: _____ DOB: _____

Reason for today's visit _____
Date of last eye examination _____

Check all that Apply

Allergic/Immunologic : □ Seasonal Allergies □ Lupus □ Sjogren's Other:

Cardiovascular : □ High Blood Pressure □ Heart Attack Other:

Endocrine : □ Diabetes : Yr. Diagnosed _____ □ Hyperthyroid □ Hypothyroid Other:

Gastrointestinal : □ Gastric Reflux Other:

Genitourinary : □ Enlarged Prostate Other:

Hematologic/Lymphatic : □ High Cholesterol □ Anemia Other:

Skin : □ Acne □ Skin Cancer : List Type/ location

Neurological : □ Stroke □ Multiple Sclerosis □ Concussion Other:

Musculoskeletal : □ Arthritis □ Fibromyalgia Other:

Psychiatric : □ Depression □ Anxiety □ Insomnia Other:

Respiratory : □ Asthma □ COPD Other:

Other medical conditions:

Primary Doctor : **Phone #**

Who may we thank for your referral?

FAMILY HISTORY

Has anyone in the **FAMILY** had/has: (Mother, Father, Sibling, OR Grandparent)

Blindness/ Poor Vision	YES	NO	Glaucoma	YES	NO
Cataracts	YES	NO	Heart Disease	YES	NO
Diabetes	YES	NO	Hypertension	YES	NO
Cancer	YES	NO	Stroke	YES	NO

SOCIAL HISTORY

What is your present weight? _____

What is your present height? _____

Do you drive?	YES	NO	Do you have visual difficulty while driving ?	YES	NO
Do you drink Alcohol?	YES	NO	IF YES how many drinks per day _____		
Do you smoke?	YES	NO	IF YES how many cigarettes or packs per day _____		
Have you ever smoked?	YES	NO	When did you quit _____		
History of drug use ?	YES	NO			

Name : _____ DOB : _____

Do you currently have any problems in the following areas ?

	YES	NO	EXPLANATION
Blurred Vision			
Tearing / Watering			
Eye pain or soreness			
Redness			
Loss of vision / Loss of side vision			
Double vision / Diplopia			
Flashes / Floaters			
Abnormal weight loss			
Dry mouth			
Shortness of breath			
Stiffness			
Headache			
Mucous discharge			
Distorted vision (halos)			
Sandy feeling / Dryness			
Itching			
Foreign body sensation			
Glare / light sensitivity			
Infection of eye or lid			
Crossed eyes, lazy eye			
Drooping eyelid			
Other (glaucoma)			

PLEASE READ AND SIGN THE FOLLOWING:

I AUTHORIZE THE PROVIDER RESPONSIBLE FOR CARE OF THE ABOVE NAMED PATIENT TO PROVIDE DIAGNOSIS AND TREATMENT OF SERVICES. INITIAL _____

I HEREBY AUTHORIZE ARROWHEAD EYE ASSOCIATES TO FURNISH INFORMATION TO MY INSURANCE COMPANY CONCERNING MY PRESENT ILLNESS OR INJURY. I HEREBY ASSIGN ARROWHEAD EYE ASSOCIATES ALL INSURANCE BENEFITS TO WHICH I AM ENTITILED FOR SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND/OR ALL FEES NOT COVERED BY MY INSURANCE PLAN.

SIGNATURE _____ DATE _____

(for office use only)

History reviewed by _____ on _____

PRIVACY PRACTICES

I _____ acknowledge that as part of my health care, Arrowhead Eye Associates may use and disclose my medical information to serve as a basis for planning for my care and treatment; a means of communication among the many health professionals who contribute to my care; a sour 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. Initial _____

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read or had the opportunity to read and understood the notice. I acknowledge that I have the following rights and privileges; the right to review the notice prior to signing the consent; the right to object to the use of my health information for directory purposes; and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health operations. Initial _____

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

_____

_____

I acknowledge that Arrowhead Eye Associates is not required to agree to the restrictions requested. I acknowle that I may revoke this form in writing, except to the extent that the organization has already taken action in reliance theron. I also acknowledge that by refusing to sign this form or by revoking this form, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further acknowledge that Arrowhead Eye Associates reserves the right to change their notice and practices prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations.
If Arrowhead Eye Associates changes their notice, I may obtain a revised copy by contacting their office.

I fully acknowledge the terms above and I consent to such disclosure for these permitted uses, including disclosures via fax.

Patient's or Representative's Signature _____ Date _____

Relationship if other than patient _____

A copy of the full Notice of Patient Privacy Act is available upon request. Initial _____

Arrowhead
EYE ASSOCIATES
Physicians and Surgeons of the Eye and Orbit

HIPAA REALEASE FORM

In accordance with HIPAA lawas we need your authorizatin to speak with anyone by you with regards your personal medical information. In the are below, please complete the information to let Arrowhead Eye Associates know how you would like us to handle you private medical information.

I, _____ , give Arrowhead Eye Associates permission to speak following people regarding my personal medical information

NAME	RELATIONSHIP

SIGNATURE : DATE :

CONSENT FOR DILATED EYE EXAMINATION

A dilated examination by your doctor is important to evaluate your retina, macula and optic nerve. Dilation eye drops are used to enlarge the pupil of the eye to allow the physician to obtain a better view of the inside of your eyes.

Causes: - Blurs vision for a length of time (varies from person to person)
- Sensitivity to light

It is not possible to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. We advise you to make alternative transportation arrangements. However, the majority of patients do drive after dilation with the assistances of the temporary sunglasses, which we provide

Risks: - Rise in eye pressures: - pain may be triggered by the dilating drops
- it may be necessary to lower the pressure by the use of drops, oral medica and / or laser treatment.
- Allergic reaction to the dilating drops.

Our doctors recommend that dilation of the pupil be performed to better examine your eyes for disease.

I have read and understand the above information regarding the dilation of my eyes and hereby authorize the doctor and / or technician to administer dilation eye drops.

Name _____ Date _____

Signature _____

CANCELLATION POLICY

We understand that circumstance can cause your schedule to change. Since your appointment time is held specially for you, we ask that you provide us with a 24-hr notice if you need to cancel. This will allow us to attempt to schedule a patient that may be waiting for an appointment. A cancellation fee of $50.00 will be charged to your account for no-show appointments and short notice cancellation.
Appointments cannot be extended to accommodate late arrivals (15 min. or more). The clinician may choose to reschedule. Under this circumstance, the appointment will be considered a late cancellation.
Please keep in mind that insurance will not cover these charges and you will be fully responsible for payment.

I _____ acknowledge that I have read and understand the cancellation policy.

Signature _____ Date _____

Arrowhead EYE ASSOCIATES
Physicians and Surgeons of the Eye and Orbit

Tel. 909-259-0903
Fax 909-466-7607
10837 Laurel Street, Suite 103
Rancho Cucamonga, CA 91730

LIFESTYLE QUESTIONNAIRE

NAME: _____ DATE: _____

What is (or was) your occupation? _____

There are a variety of options for cataract surgery that will not only give you clearer vision, but can also reduce your dependecy on glasses. Each option has potential advatages and disadvantages, depending on lifestyle and the activities you enjoy. Please help us better understand what it is important to you in order to determine which option is best suited for your lifestyle and eye health.

Please circle the following activities you do on a regular basis:

Read Newspaper/Books Drive-Nighttime Play a musical instrument Use Cell phone

Read Medicine Bottles Shop Dine in Restaurants Watch Movies in Theatre

Needlepoint/Sew Play Tennis Bicycle Photography

Crossword Puzzles Hunt or Fish Play Cards/Dominos Cook

Participate in Water Sports Paint/Dra Drive-Daytime Watch Spectator Sports Golf

Are you having difficulty with any of the activities listed above as a result of your vision?

_____

How many combined hours per day do you spend on a computer, tablet, and/or smartphone?

_____

Please share anything else you think might be important about your lifestyle or daily activities:

_____

Are there any times in your day that you wish you didn't have to wear glasses? YES NO

If YES explain: _____

Place an "X" on each continuum where it best describes how you feel about the following:

Correction of near vision: I want to wear glasses I don't want to wear glasses
(reading/use of phone)

Correction of intermediate vision: I want to wear glasses I don't want to wear glasses
(tablet/computer)

Correction of distance vision: I want to wear glasses I don't want to wear glasses
(driving/watching television)

Patient signature _____

10837 Laurel Street, Suite 103, Rancho Cucamonga, CA 91730
(909) 477-8810
FAX: (909) 466-7607

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize ***Arrowhead Eye Associates*** to disclose my protected health information as describes. below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I may see and copt the information described on this form if I ask for it, and that I will recieve a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found above, but if I do it will not affect any actions taken before receipt of my revocation.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclodure to a third party.

Patient name: _____ Date of birth: _____

Persons/orginizations to receive the information: _____

_____

The specific onformation to be released/disclosed is specific below:

- ○ Complete Medical Record
- ○ Operative Reports
- ○ X-rays
- ○ Billing and Claim Records
- ○ Laboratory (Other- Specify)

Other Specify: _____

_____

This information is to be used/disclosed for the following purpose(s) only:

_____

(no purpose need to be stated if the request is made by the patient and the patient does not wish to state the purpose)

This authorization will expire on _____

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is released to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immonodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out, and initialed it.

□Yes □No Initials _____

Signature of patient or patient's representiative_____ Date_____

(Form MUST be completed before signing.)

Printed number of patients represtative:_____

Relationship to the patient (if applicable):_____

YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT