EYE TREATMENT CENTER

CONTINUING A PRACTICE ESTABLISHED IN 1921

NAME ____________________, ____________________ BIRTH DATE____/____/____
(LAST) (FIRST) (Middle Initial) AGE _______ (mth) / (day) / (year)

ADDRESS ____ SSN_______-______-_______

CITY ________________________________ STATE _______ ZIP CODE ___________

□Male □Female □__________ MARITAL STATUS: □Single □Married □Divorced □Widowed

I live with: ____

HOME PHONE ________________________ CELL PHONE ________________________

EMAIL ADDRESS: ____

PLEASE CONTACT ME BY □TEXT* □PHONE □EMAIL (*cellular fees may apply for messages)

PREFERRED METHOD FOR APPOINTMENT REMINDERS □TEXT* □PHONE □EMAIL

I chose Eye Treatment Center because/I was Referred by (please check one):

□Dr. ________________ □Insurance plan □Hospital □Family □Friend □Close to home/work

□Saw while driving by □Internet □Other_______________

OCCUPATION ________________________ EMPLOYER ________________________

ADDRESS ____ CITY ___________________

STATE __________ZIP CODE ___________ WORK PHONE ________________________

EMERGENCY CONTACT PERSON (Someone NOT living with you)

NAME ____ RELATIONSHIP ____________________

HOME PHONE ________________________ CELL PHONE ________________________

PERSON RESPONSIBLE FOR THE BILL ________________________ Phone No________________

Address (if different) ____ Birth date: ______________

INSURANCE COMPANY____

SUBSCRIBER #________________________________ Group #__________________________

Subscriber/Guarantor Name ______________________________ Subscriber DOB_____/_____/________

Employer ____ Subscriber SSN #______-_____-________

Employer's Address____

Employer's Phone No ________________ Relationship to Subscriber □Self □Spouse □Dependent □Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Eye Treatment Center. I also authorize Eye Treatment Center to release any information to process my claims. I have received copies of the Financial Policy and Privacy Notice. I understand I am financially responsible for any balance.

SIGNATURE____ DATE____/____/____

Irene Fong Sasaki, M.D.
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Authorization to Release Medical Information to Individuals/Family Members

In accordance with federal government privacy ruled implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff at the Eye Treatment Center, An Incorporated Medical Group to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

*In the event of a critical episode or if you are unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

□ NO I do not authorize Eye Treatment Center to release any information concerning my medical care to any individual except as set forth above (*).

□ YES I authorize Eye Treatment Center verbally release any or all information concerning my medical care to the following individuals:

Name	Relationship
Name	Relationship
Patient Signature	Date
Patient LAST NAME	Patient FIRST NAME

Patient LAST NAME Patient FIRST NAME

Assignment of Benefits Form

Practice Name/Assignee: **Eye Treatment Center 3900 Long Beach Blvd. Long Beach, CA 90807**

I understand that services rendered to me at **Eye Treatment Center** are my financial responsibility and that the provider will bill my insurance company as a courtesy.

I authorize my insurance company to pay my benefits directly to **Eye Treatment Center**.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I am choosing to assign my benefits, knowing that the claim must be paid according to state or federal prompt payment guidelines.

I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company and will inform Eye Treatment Center if there are any changes to my policy.

I understand that I will be fully responsible for any outstanding balance on my account. I agree to pay any remaining balance of professional service charges not paid by my insurance when the statement is presented.
I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service.
I authorize the provider to release any information necessary to adjudicate my claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.
I authorize **Eye Treatment Center** to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.
In the event the I or the primary subscriber receives any check, draft or other payment subject to this agreement, I will forward the payment to **Eye Treatment Center.** I will immediately deliver said check, draft or payment to provider within 48 hours. If I fail to send the payment to **Eye Treatment Center** and they are forced to proceed with the collections process, I agree to be responsible for any cost incurred by the office to retrieve their monies.
Any violations of this agreement will, at provider’s election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.
A photocopy of this Assignment shall be considered as effective and valid as the original.

Paitent Signature (Parent or Guardian, if patient is a minor) Date

EYE TREATMENT CENTER

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Thank you for choosing us for your eye care needs. We are trying to find out as much as possible about your problem. Please answer the following questions. If there is anything not covered by these questions please add this information. Use the back of the page if necessary.

NAME______________________________, ______________________________
(LAST) (FIRST)

I AM HERE TODAY BECAUSE______________________________

I WOULD LIKE THE DOCTOR TO ______________________________

MY PROBLEM STARTED (When?) ______________________________

PAST PROBLEMS WITH MY EYES **□NONE**

□AMBLYOPIA	**□GLAUCOMA**	**□MACULAR DEGENERATION**	**□SURGERY**
□BLINDNESS	**□INFECTIONS**	**□RETINAL PROBLEMS**	**□OTHER**
□CATARACT	**□INJURY**	**□STRABISMUS**	
□CROSSED EYES			

I HAVE A FAMILY MEMBER WITH **□NONE**

□AMBLYOPIA	**□GLAUCOMA**	**□MACULAR DEGENERATION**	**□SURGERY**
□BLINDNESS	**□INFECTIONS**	**□RETINAL PROBLEMS**	**□OTHER**
□CATARACT	**□INJURY**	**□STRABISMUS**	
□CROSSED EYES			

I HAVE HAD MY EYES EXAMINED IN THE PAST BY ______________________________

DATE OF MOST RECENT EYE EXAM ______________________________

(*FOR THOSE WHO WEAR GLASSES OR CONTACT LENSES*)
I AM SATISFIED WITH MY PRESENT GLASSES/CONTACT LENSES? □YES □NO

If no, why? ______________________________

I HAVE WORN EYEGLASSES SINCE (When?) ______________________________

I HAVE WORN CONTACT LENSES SINCE (When?) ______________________________

MY HOBBIES ARE ______________________________

IN ADDITION I USE MY EYES FOR □Computer □Tablet □Reading □Driving

____

____

NAME______________________________, ______________________________
(LAST) (FIRST)

ALLERGIES? □ NO □YES ______________________________

List of Allergies ______________________________

CURRENT MEDICATIONS □None

____

____

____

CURRENT EYE MEDICATIONS □None

____

____

Tobacco Use: □Never □Quit, when:____________**□Yes, I use** _____**Packs/Day**

Alcohol Use: □Never □Quit, when: ___________**□Yes, I use** _____**Drinks/Week**

Marijuana Use: □No □Yes, I currently use _____**Daily**______**Weekly**_______**Infrequently**

Recreational Drugs: □No □Yes, type: ______________________________

AT PRESENT I HAVE THE FOLLOWING SYMPTOMS/PROBLEMS □NONE

□ABNORMAL PUPIL
□BLIND SPOT(S)
□BLINKING TOO MUCH
□BLURRED VISION
□CHANGING VISION
□COLOR VISION
□CRUSTY EYELIDS
□DECREASED VISION
□DEPTH PERCEPTION
□DISCHARGE
□DISCOMFORT
□DOUBLE VISION
□DRYNESS
□FLASHING LIGHTS
□FLOATERS
□FLUCTUATING VISION
□HALOS AROUND LIGHTS
□FREQUENT INFECTIONS
□ITCHING
□JAGGED LINES
□LIGHT SENSITIVITY
□MATTERING
□NIGHT VISION PROBLEMS
□PAIN AROUND EYES
□PAIN BEHIND EYES
□PAIN IN EYES
□PRESSURE BEHIND EYES
□PRESSURE IN EYES
□PROTRUSION
□PUFFINESS
□RED EYES
□RED EYELIDS
□SPASMS
□TEARING
□OTHER

THESE SYMPTOMS HAVE BOTHERED ME IN THE PAST □NONE

□ABNORMAL PUPIL
□BLIND SPOT(S)
□ BLURRED VISION
□CATARACT
□CROSSED EYES
□DECREASED VISION
□DOUBLE VISION
□EYE INJURY
□EYE TUMOR
□FLASHES
□FLOATERS
□GLAUCOMA
□FLOATERS
□FREQUENT INFECTIONS
□IRITIS OR UVEITIS
□LAZY EYE
□LOSS OF VISION
□OCCUPATIONAL PROBLEMS
□RETINAL PROBLEM
□SERIOUS EYE INFECTIONS
□OTHER

OTHER INFORMATION TO HELP THE DOCTOR

____

____

NAME________________________________,____

(LAST) (FIRST)

SYMPTOMS I AM CURRENTLY HAVING □**NONE**

□Lack of Energy
□Unexplained Weight Loss/Gain
□Loss of Appetite
□Fever
□Night Sweats
□Jaw Pain when Eating
□Scalp Tenderness
□Prior Diagnosis of Cancer
□Sinus Problems
□Runny Nose
□Post-Nasal Drip
□Ringing in Ears
□Wheezing
□Chest Pains

□Swelling of Feet or Legs
□Night Sweats
□Prolonged Cough
□Slow Heart Rate
□Prior Tuberculosis
□Heartburn
□Constipation
□ Diarrhea
□Abdominal Pain
□Difficulty Swallowing
□Painful urination
□Frequent Urination
□Prostate Problems
□Bladder Problems
□Impotence
□Joint Pain

□Swelling of Joints
□Back/Neck Pain
□Frequent Headaches
□Weakness
□Problems with Walking
□Problems with Balance
□Dizzyness
□Depression
□Anxiety
□Mood Swings
□Hallucinations
□Intolerance to Heat/Cold
□Menstrual Irregularities
□Frequent Hunger/Thirst
□Persistent Rash
□New Skin Lesion

□Tremor
□Mouth Sores
□Facial Numbness
□Tooth Pain
□Irregular Heartbeat
□Shortness of Breath
□Racing Heart
□Easy Bleeding/Bruising
□Anemia
□Abnormal Blood Tests
□Seasonal Allergies
□Hayfever
□Itching
□Frequent Infections
□Low Immunity
□Exposure to HIV

MAJOR ILLNESSES THAT I HAVE/HAD □**NONE**

□Alcoholism
□Anemia
□Asthma
□Arthritis
□High Blood Pressure
□Rheumatoid Arthritis
□COPD
□Cancer
□Blood Clots
□Arrhythmia

□Atrial Fibrillation
□Aneurysm
□Pacemaker
□Chest Pains
□Heart Attack
□Hepatitis
□Organ Transplant
□Colitis
□Ulcer
□Gout

□Stroke
□Depression
□Dementia
□Diabetes
□Drug Abuse
□Epilepsy
□Thyroid Problems
□Migraines
□Lupus
□Stroke

□HIV
□Impotence
□Kidney Disease
□Liver Disease
□Tuberculosis
□Fibromyalgia
□Sjogrens Disease
□Shingles

SIGNATURE ______________________________ **DATE** ____________________

UPDATE ______________________________ **DATE** ____________________

UPDATE ______________________________ **DATE** ____________________