

Welcome To Our Office

Name: _____
(Last) (First) (Middle) (Date)

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: (_____) Work Phone: (_____) DOB: _____

Email: _____

Sex: _____ Weight: _____ Ht: _____ Family Physician: _____

Occupation: _____ Primary Language: _____

Date of last eye exam: _____ By Whom: _____

Reason for today's exam: _____

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT

Name: _____
(Last) (First) (M.I.)

Address: _____
(Street) (City) (State) (Zip Code)

INSURANCE INFO

Primary Insurance: _____

Insurance ID#: _____

Informed Consent for Dilation

I am aware that dilation drops could result in the following; blurry vision, sensitivity to light, inability to judge distance, imbalance. You may elect to schedule a dilation at a later time. I have read and understand the risk referred to the above and hereby consent to having my eyes dilated.

Notice of Privacy Practices

As of April 14, 2003 a new law took effect called the Health Insurance Portability and Accountability Act, Referred To As "HIPAA". Part of the law protects you against the unauthorized use of your personal medical files. A copy of the HIPAA law is available upon request.

Assignment of Benefits Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. William A. Olivos for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. William A. Olivos to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. I have requested medical services from Dr. William A. Olivos on behalf of myself and/or my dependents, and understand that by making this request, I become financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature _____ Date _____

COMPLETE MEDICAL HISTORY

SOCIAL HISTORY

1. Do you wear glasses? Y N If so how long? _____
2. Do you drink alcohol? Y N If so how much? _____
3. Do you smoke now? Y N If so how much? _____
4. Do you live alone? Y N
5. Do you wear contacts? Y N

EYE HISTORY—Do you, any of your relatives or family members have the following?:

Blindness _____ Eye Surgery _____
Cataracts _____ Glaucoma _____
Corneal Diseases _____ Macular Degeneration _____
Diabetes _____ Retinal Disease _____

COMMENTS: _____

ALLERGIES TO MEDICATIONS: _____

MEDICATIONS: _____

ASPIRIN PRODUCTS: _____

Previous surgeries/hospitalizations? Y N

Procedure: List any other serious illness or accidents not listed above: _____

CHEST/LUNGS

Asthma _____
Chronic Cough _____
COPD _____
Emphysema _____
Shortness of Breath _____
Other _____

HEART/CARDIOVASCULAR

Anginal syndrome _____
Bleeding Disorders _____
Cardiac Arrhythmia _____
Circulation Problems _____
Congestive Heart Failure _____
Heart Attack _____
High Blood Pressure _____
Other _____

ABDOMEN

Bladder Infection _____
Bowel/Intestinal Problem _____
Chronic Liver Disorder _____
Liver Disease _____
Gall Bladder Problem _____
Hepatitis _____
Kidney Infection _____
Kidney Stones _____
Nausea/Vomiting _____
Prostate Disorders _____
Renal Disease _____
Stomach Problems _____
Ulcers _____
Urinary Problems _____
Uterine Disorders _____
Other _____

HEENT

Dental Problems _____
Sinus Problems _____
Hearing Loss _____
Other _____

EXT/NEUROLOGICAL

Arthritis _____
Convulsions _____
Cramping/Pain in Leg _____
Fractures _____
Headaches _____
Joint Replacement _____
Nerve Palsy _____
Phlebitis _____
Previous Stroke _____
Rheumatism _____
Rheumatic Diseases _____
Shingles _____
Other _____

OTHER

Bleeding Tendency _____
Bruising Tendency _____
Cancer _____
Diabetes _____
Dizziness _____
Fainting _____
Hormone Imbalance _____
Immune Deficiency _____
Psychiatric Episodes _____
Thyroid Disease _____
Other _____

BOTH PAGES OF HISTORY REVIEWED _____

(Physicians Initials)