Northern California Retina---Vitreous Associates Medical Group, Inc.
Patient Registration

Last name:

First name:

Preferred name:

Middle name: Suffix:

Former last name:

Sex: ☐ Male ☐ Female

DOB:

Social Security #:

Address:

Address (continued):

Zip Code:

City:

State:

Home phone: ( ) - ☐ None

Mobile phone: ( ) - ☐ None

Work phone: ( ) - ☐ None

Email: ☐ None

Contact Preference: ☐ Home ☐ Work ☐ Mobile ☐ Mail

Language: ☐ Decline

Race: ☐ Decline

Ethnicity: ☐ Decline

<u>Marital Status:</u> ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Partner

Referring Doctor:

Primary Care Provider:

Primary Insurance:

Address (Street):

Address (City, State, Zip):

ID #:

Group #:

Subscriber Name:

Subscriber DOB:

Subscriber SSN:

Secondary Insurance:

Address (Street):

Address (City, State, Zip):

ID #:

Group #:

Subscriber Name:

Subscriber DOB:

Subscriber SSN:

Emergency Contact:

Relationship:

Phone:

Please Read and Sign the <u>Consent for Use and/or Disclosure of Information Form</u> on reverse side of this form ⇨

Northern California Retina-Vitreous Associates Medical Group, Inc.

Consent for Use and/or Disclosure of Information:

I hereby give consent to Northern California Retina-Vitreous Associates Medical Group, Inc. to use and disclose my protected health information for the purpose of treatment, payment and health care operations. I also understand that my insurance carrier may require an authorization from my primary care physician or general ophthalmologist in order to approve this visit for payment. I understand that I will be financially responsible for all charges incurred at the time of visit should that authorization be denied. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to change the terms of our Notice of Privacy Practices. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or heath care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this request.

Print Name: ____ Date: ______________________

Signature: ____

If you are signing as the patient's representative:

I authorize the release of medical information on my behalf to those listed below:

Name: ___________________________________ Relationship: _________________ Initial: ________

Name: ___________________________________ Relationship: _________________ Initial: ________

You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request to the address below:

Northern California Retina-Vitreous Associates Medical Group, Inc.
Attention: Privacy Officer
2485 Hospital Drive, Suite 200
Mountain View, CA 94040

MEDICAL HISTORY
& REVIEW OF SYSTEMS

NAME: ______________________________ DATE: ____________________

Please check all boxes that apply to you.

Endocrine Problems: ☐ None
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other ____________________

Cardiovascular Problems: ☐ None
- ☐ High Blood Pressure
- ☐ Heart Attack or Chest Pain (Angina)
- ☐ Abnormal Heart Beat
- ☐ Heart Failure
- ☐ Angioplasty or Heart Surgery
- ☐ Other ____________________

Respiratory Problems: ☐ None
- ☐ Shortness of Breath
- ☐ Coughing
- ☐ Asthma/Emphysema/Chronic Obst. Pulm. Dz.
- ☐ Other ____________________

Head/Ear/Nose/Throat Problems: ☐ None
- ☐ Headaches/Tender Scalp/Jaw Pain/Stiff Neck
- ☐ Hearing Loss
- ☐ Other ____________________

Digestive Problems: ☐ None
- ☐ Reflux
- ☐ Constipation/Diarrhea
- ☐ Other ____________________

Genitourinary Problems: ☐ None
- ☐ Dialysis or Kidney Failure
- ☐ Sexually Transmitted Disease
- ☐ Other ____________________

Musculoskeletal Problems: ☐ None
- ☐ Osteo Arthritis or Rheumatoid Arthritis
- ☐ Migratory or Moving Joint Pains
- ☐ Lower Back Pains
- ☐ Other ____________________

Neurologic/Psychiatric Problems: ☐ None
- ☐ Stroke or Transient Ischemic Attacks
- ☐ Mood Disorder: Depression/Anxiety/etc.
- ☐ Other ____________________

Skin Problems: ☐ None
- ☐ Rashes
- ☐ Sores in Mouth or Genitals
- ☐ Other ____________________

Cancer: ☐ None
- ☐ Type/s: ____________________

____

____

Blood/Immune Problems: ☐ None
- ☐ Bleeding or Clotting Problems
- ☐ Auto-immune Disease ____________________
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Other ____________________

Constitutional Symptoms: ☐ None
- ☐ Fever
- ☐ Fatigue
- ☐ Unexpected Weight Loss or Gain

***"Family"* Eye History (Other than You):** ☐ None
- ☐ Macular Degeneration
- ☐ Retinal Tears or Detachments
- ☐ Glaucoma
- ☐ Other ____________________

Social History: ☐ None
- ☐ Live Alone
- ☐ Live with (relationship) ____________________
- ☐ Retired
- ☐ Occupation ____________________

Habits: ☐ None
- ☐ Tobacco use ____________________
- ☐ Alcohol use ____________________
- ☐ Street Drug use ____________________
- ☐ Herbal/Vitamin Supplements ____________________

____

____

Surgeries: ☐ None

____

____

____

____

Please bring all of your medications, supplements and eye drops or a complete list of them with you to your appointment.

____________________ M.D.

Northern California
Retina Vitreous Associates
Established in 1983

MEDICATION & ALLERGY LIST

Patient Name:____________________________ **DOB:**____________

Please list all **Eye Drops** you are taking:

Name	Right / Left / Both Eyes?	Frequency

Please list all **Medicines, Insulin, Blood Thinners, Vitamins, & Supplements** you are taking:

Name	Dose	Frequency

ALLERGIES

PREFERRED PHARMACY:

Name ________________________

Location ________________________

Phone ________________________

NORTHERN CALIFORNIA
RETINA VITREOUS ASSOCIATES
ESTABLISHED IN 1983

24 Hour Cancellation & "No Show" Fee Policy

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment, patient care may be compromised. Without providing proper notice, other patients are prevented from receiving proper care. Therefore, the Physicians of Northern California Retina Vitreous Associates will charge a fee of $50.00 for each missed (No Show) appointment which, absent a compelling reason, is not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No Shows" in any 12 month period will result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy

____

Printed, Last Name, First Date

____

Signature

NORTHERN CALIFORNIA
RETINA VITREOUS ASSOCIATES
ESTABLISHED IN 1983

AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name ____ Date of Birth __________________________

Address _____________________________________ City / State / Zip ____________________________________

I Hereby Authorize the Disclosure of my Health Information From:

____
Name of Person/Organization Releasing Information

____
Address City / State / Zip

____
Phone Number // Fax Number

To Release my Information To:

____
Name of Person/Organization Receiving Information

____
Address City / State / Zip

____
Phone Number // Fax Number

INFORMATION TO BE RELEASED:
_______Complete Medical Record
_______Medical Records for Specific Dates of Service (please list) from____________ to ___________
_______Other (please list) ____

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:
I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____________________________________ X____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

____
Description of Personal Representative's Authority (attach necessary documentation)

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Date Sent: ______________ **By:** _____________________ **Via:** ________________