Account #:	



Patient's Name			
	Last	First	Middle
Address			
			Apt/Suite
	City	State	Zip
Home Phone		Work Phone	
Mobile Phone		Email	
Sex: M F	Marital Status: ☐ Single ☐ Married	☐ Divorced ☐ Widowed	
Social Security		Date of Birth	
Primary Care Dr.		Preferred Pharmacy	
Primary Care Dr. Phone Nbr.		Pharmacy Phone	
• .	act and Phone Nbr.		
If the patient is u	under the age of 18, who is responsib	le for the patient?	
Name	Last	First	Middle
Address			
	City	State	Zip
Social Security			
Primary Medical Insurance		ID	
Subscriber			
	Last	First	Middle
Date of Birth Secondary Medi	cal		
Insurance		ID	
Subscriber	Lact	First	Middle
	Last	First	Middle
Date of Birth			
Vision Insurance		ID	

Account #:	
$\pi$	

Due to new regulations mandated at both the state and federal level, we are now obligated to collect the
race, ethnic background and preferred language of each patient. This information will go into your medical
record and remains strictly confidential.

Please circle your race	American Indian or Alaska Native
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Asian

Black or African American

Native Hawaiian or Other Pacific Islander

Other Race or Multiple Races

White

Please circle your ethnic

Hispanic or Latino

background

Non Hispanic or Latino

What is your preferred language

Please circle how would you prefer to be notified/reminded about future appointments, optical orders and contact lens orders?

Text message

Call my mobile number Call my work number Call my home number

Email only

I hereby consent to a health examination, related diagnostic procedures and treatments provided by the Eye Center. I hereby authorize my insurance company(s) to remit directly to the Eye Center all payment of benefits otherwise payable to me under the provision of my policy(s). I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to the Eye Center for any services provided to me. I hereby authorize the release of this information needed to determine benefits payable for related services. I also authorize the use of any photographs or data collections taken to document my ocular condition for routine care or use in research and professional publication. Photo static copies of this authorization will be considered valid as the original.

If my insurance company requires referrals, vouchers or authorizations, I will present these to the receptionist immediately. Failure to do so will make me responsible for full payment once services are rendered.

Signature						
	(Please circle one)	Patient	Parent	Legal Guardian	Responsible Party	
	I have received a co	py of the '	'Notice of	f Privacy Practices	п	
initial						

## Berkeley Eye Center GENERAL HISTORY

	atient Name:			_ Date:	DOR:		Sex: I	viale / Fer
Self   Family   Self   Family   Cardiac   Sationtestinal   Self   Family   Cardiac   Self   Family   Cardiac   Self   Family	. Allergies:							
1. Heart disease	. History of following diseases (check if YES):	Self	Family				Self	Fami
2. High blood pressure	Cardiac			Gastroii	ntestinal			
3. Chest pain	1. Heart disease			1. Gastro-	esophageal refl	ux		
1. Asthma	2. High blood pressure			2. Hiatal h	ernia			
1. Asthma	3. Chest pain			3. Hepatit	is (Type:	)		
2. Bronchitis 3. Emphysema 4. Oxygen dependence 4. Retinal detachment 4. Retinal detachment 4. Retinal detachment 4. Retinal detachment 5. Seizures 6. Seizures 7. Harring aid use 8. Seizures 8. Larring aid use 8. Seizures 9. Larring aid use 9. Seychiatric 9. Larring aid use 9. Seizures 9. Se	Respiratory			Eye dise	ease			
3. Emphysema	1. Asthma			1. Catarao	ots			
A. Retinal detachment	2. Bronchitis			2. Glauco	ma			
Sezivos   Sezi	3. Emphysema			3. Macula	r degeneration			
1. Stroke 2. Seizures 3. Hearing aid use  ### Richard Stroke 2. Seizures 4. Chronic cough 2. Hearing aid use  ### Psychiatric 1. Depression 2. Anxiety 4. Depression 2. Anxiety 4. Depression 2. Anxiety 4. Depression 3. Bleeding disorders (Type:	4. Oxygen dependence			4. Retinal	detachment			
2. Seizures  Kidney  1. Renal insufficiency/failure 2. Dialysis dependence Endocrine 1. Depression 2. Anxiety  Other 1. Cancer (Type:) 2. HIV 2. Joint pain (Location:)  Current Medications:  Previous surgeries:  Tobacco use: Yes / No Quantity: If you quit, how long ago?  Alcohol consumption? Yes / No Quantity: Yes / No  Do you suffer from any of the following?  Blurry vision Sinus problems  Valenty vision Sinus problems  Plashes of light Pain in your eyes Floaters Seasonal Allergies  Dizziness  Other  1. Depression 2. Anxiety  1. Cancer (Type:) 2. HIV 3. Bleeding disorders (Type:) 4 Sinus problems 5 If you quit, how long ago?  If you quit, how long ago?  Yes / No  Previous surgeries: Yes / No  Sinus problems Flashes of light Flashes of light Seasonal Allergies  Watery eyes Halos Floaters Dizziness Other	Neurological			Ear/Nos	e/Throat			
Psychiatric	1. Stroke			1. Chronic	cough			
1. Renal insufficiency/failure 2. Dialysis dependence  Endocrine 1. Diabetes (Type) 2. Thyroid problems  Musculoskeletal 1. Walker/wheelchair use 2. Joint pain (Location:) 2. Joint pain (Location:)  Tobacco use: Yes / No Quantity: If you quit, how long ago?  Alcohol consumption? Yes / No Quantity:  Drug abuse? Yes / No Quantity:  If you are female, possibility of pregnancy? Yes / No  Do you have an Advanced Directive for Healthcare (Living Will)? Yes / No  Do you suffer from any of the following?  Blurry vision Sinus problems Flashes of light Dry eyes Headaches Halos Seasonal Allergies Dizziness Other Seasonal Allergies Dizziness Other Seasonal Allergies Other Sinus problems Floaters Seasonal Allergies Dizziness Other Sinus problems Floaters Seasonal Allergies Dizziness Other Sinus problems Floaters Seasonal Allergies Seasonal Allergies Other Sinus problems Floaters Seasonal Allergies Seasonal Allergies Other Sinus problems Floaters Seasonal Allergies Other Seasonal Allergies Other Sinus problems Floaters Seasonal Allergies Other Seasonal Allergies Other Sinus problems Floaters Seasonal Allergies Other Sinus problems Floaters Seasonal Allergies Other Sinus problems Floaters Seasonal Allergies Sinus problems Floaters Sinus problems Floaters	2. Seizures			2. Hearing	g aid use			
2. Dialysis dependence  Endocrine 1. Diabetes (Type) 2. Thyroid problems 1. Walker/wheelchair use 2. Joint pain (Locations:  Previous surgeries:  Tobacco use: Yes / No Quantity: If you quit, how long ago?  Alcohol consumption? Yes / No Quantity: If you are female, possibility of pregnancy?  Previous are female, possibility of pregnancy?  Do you have an Advanced Directive for Healthcare (Living Will)? Yes / No  Do you suffer from any of the following?  Blurry vision Sinus problems Flashes of light Dry eyes Headaches Halos Seasonal Allergies Dizziness Other Other Seasonal Allergies Other Other Seasonal Allergies Other Sinus problems Floaters Seasonal Allergies Other Sinus prouses Floaters Seasonal Allergies Other Sinus prouses Floaters Seasonal Allergies Other Sinus prouse Floaters Seasonal Allergies Other Sinus prouses Floaters Seasonal Allergies Sinus prouses Floaters Seasonal Allergies Sinus prouses Floaters Sinus prouses Sinus prous	Kidney			Psychia	tric			
Content   Cont	Renal insufficiency/failure			1. Depres	sion			
1. Diabetes (Type) 2. Thyroid problems 2. HIV 3. Bleeding disorders (Type:) 4 2. Joint pain (Location:)  Current Medications:  Previous surgeries:  Tobacco use: Yes / No Quantity: If you quit, how long ago?  Alcohol consumption? Yes / No Quantity:  Drug abuse? Yes / No Type:  If you are female, possibility of pregnancy? Yes / No  Do you have an Advanced Directive for Healthcare (Living Will)? Yes / No  Do you suffer from any of the following?  Blurry vision Sinus problems Flashes of light Dry eyes Headaches Halos Watery eyes Headaches Halos Seasonal Allergies Other  1. Cancer (Type:) 2. HIV  3. Bleeding disorders (Type:) 4  4  5  1. Cancer (Type:) 2. HIV  3. Bleeding disorders (Type:) 4  5  Flashes of light  Pain in your eyes Floaters  Other  Other	2. Dialysis dependence			2. Anxiety				
2. HIV  Musculoskeletal 1. Walker/wheelchair use 2. Joint pain (Location:  Current Medications:  Tobacco use: Yes / No Quantity:  Drug abuse? Yes / No Quantity:  If you quit, how long ago?  Jif you are female, possibility of pregnancy?  Yes / No  Do you have an Advanced Directive for Healthcare (Living Will)?  Do you suffer from any of the following?  Blurry vision  Dry eyes  Headaches  Halos  Watery eyes  Pain in your eyes  Seasonal Allergies  Jizziness  Ji	Endocrine			Other				
Musculoskeletal 3. Bleeding disorders (Type:) 1. Walker/wheelchair use 4 2. Joint pain (Location:) 5  Current Medications:  Previous surgeries:  Tobacco use: Yes / No Quantity: If you quit, how long ago?  Alcohol consumption? Yes / No Quantity:  Drug abuse? Yes / No Type:  If you are female, possibility of pregnancy? Yes / No  Do you have an Advanced Directive for Healthcare (Living Will)? Yes / No  Do you suffer from any of the following?  Blurry vision Sinus problems Flashes of light Pregnancy Planting yeyes Headaches Halos Matery eyes Pain in your eyes Floaters Other	1. Diabetes (Type)			1. Cancer	(Type:	)		
1. Walker/wheelchair use 2. Joint pain (Location: 5 5 5	2. Thyroid problems			2. HIV				
Current Medications:    Previous surgeries:	Musculoskeletal			<ol><li>Bleedin</li></ol>	g disorders (Typ	oe:	_)	
Current Medications:  Previous surgeries:  Tobacco use: Yes / No Quantity:	1. Walker/wheelchair use			4			_	
Previous surgeries:  Tobacco use: Yes / No Quantity: If you quit, how long ago?  Alcohol consumption? Yes / No Quantity:  Drug abuse? Yes / No Type:  If you are female, possibility of pregnancy? Yes / No  Do you have an Advanced Directive for Healthcare (Living Will)? Yes / No  Do you suffer from any of the following?  Blurry vision Sinus problems Flashes of light Dry eyes Headaches Halos Watery eyes Pain in your eyes Floaters Seasonal Allergies Dizziness Other	2. Joint pain (Location:)			5			_	
Alcohol consumption? Yes / No Quantity:	Previous surgeries:							
Drug abuse? Yes / No Type:	Tobacco use: Yes / No	Quar	ntity:		If you	u quit, how	long ago?	
If you are female, possibility of pregnancy?  Do you have an Advanced Directive for Healthcare (Living Will)?  Yes / No  Do you suffer from any of the following?  Blurry vision Sinus problems Flashes of light Dry eyes Headaches Halos Watery eyes Pain in your eyes Floaters Seasonal Allergies Dizziness Other	<b>Alcohol consumption?</b> Yes	/ No Quar	ntity:					
Do you have an Advanced Directive for Healthcare (Living Will)? Yes / No  Do you suffer from any of the following?  Blurry vision Sinus problems Flashes of light Dry eyes Headaches Halos Watery eyes Pain in your eyes Floaters Seasonal Allergies Dizziness Other	Drug abuse?	es / No	Туре:					
Do you suffer from any of the following?         Blurry vision       Sinus problems       Flashes of light         Dry eyes       Headaches       Halos         Watery eyes       Pain in your eyes       Floaters         Seasonal Allergies       Dizziness       Other	If you are female, possibility of p	regnancy?	?		Yes / No			
Blurry visionSinus problemsFlashes of lightDry eyesHeadachesHalosWatery eyesPain in your eyesFloatersSeasonal AllergiesDizzinessOther	Do you have an <b>Advanced Dire</b>	ctive for H	ealthcare (	Living Will)?	Yes / No			
Do you wear glasses or contact lenses? Yes / No If yes: Extended Daily Hard Soft	Blurry vision Dry eyes Watery eyes	following?  	Headach Pain in y	ies our eyes		Halos Floater	_	
	Seasonal Allergies							