BERKELEY EYE CENTER

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 ____________________

Emergency Contact and Phone Nbr. ____

If the patient is under the age of 18, who is responsible 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 Medical Insurance ____________________ ID ____________________

Subscriber ____
Last First Middle

Date of Birth ____________________

Vision Insurance ____________________ ID ____________________

Account #: ______________________

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
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Other Race or Multiple Races
- White

Please circle your ethnic background

- Hispanic or Latino
- 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 copy of the "Notice of Privacy Practices"

initial

Berkeley Eye Center
GENERAL HISTORY

Patient Name: ________________________ **Date:** __________ **DOB:** ___________ **Sex:** Male / Female

1. Allergies: ____

2. History of following diseases (check if YES):

	Self	Family		Self	Family
Cardiac			**Gastrointestinal**		
1. Heart disease			1. Gastro-esophageal reflux		
2. High blood pressure			2. Hiatal hernia		
3. Chest pain			3. Hepatitis (Type: _______)		
Respiratory			**Eye disease**		
1. Asthma			1. Cataracts		
2. Bronchitis			2. Glaucoma		
3. Emphysema			3. Macular degeneration		
4. Oxygen dependence			4. Retinal detachment		
Neurological			**Ear/Nose/Throat**		
1. Stroke			1. Chronic cough		
2. Seizures			2. Hearing aid use		
Kidney			**Psychiatric**		
1. Renal insufficiency/failure			1. Depression		
2. Dialysis dependence			2. Anxiety		
Endocrine			**Other**		
1. Diabetes (Type________)			1. Cancer (Type: ___________)		
2. Thyroid problems			2. HIV		
Musculoskeletal			3. Bleeding disorders (Type: _______)		
1. Walker/wheelchair use			4. ______________________________		
2. Joint pain (Location: ______)			5. ______________________________		

3. Current Medications:

____

____

4. Previous surgeries: ____

____

5. Tobacco use: Yes / No Quantity: ______________ If you quit, how long ago? _____________

6. Alcohol consumption? Yes / No Quantity: __________________________

7. Drug abuse? Yes / No Type: _____________________________

8. If you are female, possibility of **pregnancy**? Yes / No

9. Do you have an **Advanced Directive for Healthcare** (Living Will)? Yes / No

10. 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	____

11. Do you wear glasses or contact lenses? Yes / No **If yes:** Extended Daily Hard Soft

SIGNATURE: ____

BEC-001 (01/08)