ADVANCED VISION CARE

Nicole Fram MD Sahar Bedrood MD, PhD Juliana Nghiem OD Melody Kordnaij OD

PATIENT INFORMATION FORM

NAME_____

DATE OF BIRTH_____ **Gender**_____

ADDRESS _____

CITY, STATE and ZIP _____

CELL PHONE_____

HOME PHONE_____

EMAIL _____

REFERRING DOCTOR/PERSON:_____

PRIMARY CARE PHYSICIAN:_____

CURRENT OCCUPATION: _____

INSURANCE INFORMATION – Fill out below if card is not present

PRIMARY: _____

SUBSCRIBER NAME & DOB: (if not yourself) _____

SECONDARY: _____

SUBSCRIBER NAME & DOB: (if not yourself) _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

BEST WAY TO CONTACT

☐ PHONE ☐ TEXT ☐ EMAIL

Have you ever been told you have dry eyes? □ Yes □ No When? _____Which Eye or both? _____

2080 Century Park East, Suite 911, Los Angeles, California 90067 310 229 1220 ph. 310 229 1222 fax
www.advancedvisioncare.com

Do you have any of the following symptoms?

□ Redness □ Tired eyes, eye fatigue

□ Burning □ Stringy mucus discharge

□ Itching □ Foreign body sensation

□ Light sensitivity □ Contact lens discomfort

□ Excess tearing/watering eyes □ Scratchy feeling of sand /gritty feeling

Have you had any of the following surgeries?

Cataract YES/NO Glaucoma YES/NO Refractive surgery YES/NO

Do you use?

□ Contact lenses □ Over the counter eye drops such as artificial tears?

□ Restasis □ Rx eye drops for Glaucoma (e.g., Xalatan, Timolol)

□ Rx eye drops for allergy (e.g., anti-inflammatory, antihistamine) □ Nutritional supplements (e.g., flaxseed oil, omega-3)

Are your symptoms related to the following conditions?

□ Windy Conditions □ Places with low humidity (e.g., airplanes/hospital)

□ Areas that are air conditioned/heated

Are you taking any of the following medications?

□ Antihistamines/Decongestants □ Hormone Replacement Therapy

□ Antidepressant or anti-anxiety □ Antihypertensive (e.g., Diuretic.)

□ Accutane or other oral treatment for acne

Medical History Questionnaire

Reason For Visit- *(Include which eye); Examples: blurred vision, dry eyes, cataract, cornea or glaucoma evaluation, pain, redness, tearing*

How long have you been experiencing these symptoms? _____

Review of Systems: *Are you currently receiving treatment or have previously been treated for any of the following conditions?*

Fever/Weight Loss Other – Please Specify	
Eyes Glaucoma / Cataract / Lazy Eye / Retina Problems / LASIK or Laser Vision Correction / Other – Please Specify	
Cardiovascular Heart Problems / Chest Pain / Irregular Heart Beat / High Blood Pressure / High Cholesterol / Other – Please Specify	
Respiratory Asthma / Shortness of Breath / Wheezing / Coughing / Other – Please Specify	
Gastrointestinal Heartburn / Abdominal Pain / Diarrhea / Vomiting / Other – Please Specify	
Integumentary Skin Rashes / Excessive Dryness / Other – Please Specify	
Musculoskeletal Muscle Aches / Joint Pain / Swollen Joints / Other – Please Specify	
Neurological Numbness / Weakness / Headaches / Other – Please Specify	
Hematologic/Lymphatic Blood Disorders / Leukemia / Other – Please Specify	
Allergic/Immunologic Hay Fever / Allergies / Other – Please Specify	
Endocrine Hypothyroid / Hyperthyroid / Thyroid Disease Autoimmune Disease / Other – Please Specify	
Psychiatric Depression / Anxiety / Other – Please Specify	

Past Surgeries - *List any surgeries on major organs, excluding procedures for the eyes*: _____
_____
_____

Family History: *Do any of the following medical or eye diseases run in your family? If YES, please circle and note the relationship to you below*

Ocular		**Explanation/Relationship**
Cataract at a Young Age	[No]	[Yes] _____
Glaucoma	[No]	[Yes] _____
Macular Degeneration	[No]	[Yes] _____
Retinal Detachment	[No]	[Yes] _____
Medical		
Diabetes	[No]	[Yes] _____
Hypertension	[No]	[Yes] _____
Heart Disease	[No]	[Yes] _____
Stroke	[No]	[Yes] _____
Arthritis, Lupus, Rheumatoid Arthritis	[No]	[Yes] _____
Cancer	[No]	[Yes] _____

List of Medications: *List name of medication, how often you take it and dosage*: _____
_____
_____

Have you **EVER** used **TAMSULOSIN or FLOMAX**? [No] ____ [Yes] ____

List of Medication Allergies (*examples: Penicillin, Sulfa)*:_____
_____

Do you have problems with anesthesia? [No] _____ [Yes] _____ If yes, please explain: _____
_____

Do you drive?	[No] _____ [Yes] _____
Do you drive at night?	[No] _____ [Yes] _____
Do you drink alcohol?	[No] _____ [Yes] _____How much? _____
Do you smoke?	[No] _____ [Yes] _____How much? _____

Patient Signature X_____ **Date:** _____

Doctor Signature X_____ **Date:** _____

ADVANCED VISION CARE

Nicole Fram, MD Sahar Bedrood, MD Ayaka Sato, OD Samantha Dodda, OD
Samuel Masket, MD

2080 Century Park East, Suite 911, Los Angeles, California 90067 310 229 1220 ph. 310 229 1222 fax
www.advancedvisioncare.com

Permission to discuss medical care: **I hereby give Advanced Vision Care (AVC) permission to discuss and answer any questions regarding my medical care/condition to (must include translators):**

Name: _____ Relationship: _____ Phone #_____

Assignment of Benefits & Confidentiality:

Assignment of Insurance benefits: I hereby authorize direct payments to Advanced Vision Care (AVC) for services rendered under their supervision. I understand that I am financially responsible for any balance unpaid or not covered by my insurance.

Authorization to release information: I hereby authorize AVC to release any medical or incidental information that may be required for either medical care or in processing application for financial benefit.

Medicare: I certify that the information given by me is correct. I authorize release of all medical records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

Protected Health Information:

Advanced Vision Care Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You also have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:

- **My protected health information may be disclosed or used for treatment, payment or health care operations.**
- **I have the right to review AVC's "Notice of Privacy Practices".**
- **AVC has the right to change their policies.**
- **I have the right to restrict the use of my information but AVC does not have to agree to those restrictions.**
- **I may revoke this consent in writing at any time and all future disclosures will then cease. AVC may condition treatment upon the execution of this consent.**

_____ **Date:** _____

Signature of Patient or representative

_____

Relationship, if other than patient

OFFICE POLICIES

With my consent, Dr. Fram/Dr. Bedrood/Dr. Sato/Dr. Dodda may use and disclose protected health information about me for treatment, payment, and healthcare operations. Dr. Fram /Dr. Bedrood/Dr. Sato/ Dr. Dodda or their designated staff and associates may contact me or leave messages at any of the addresses, fax or phone numbers that I have provided. I understand that I may be contacted by mail or telephone regarding my appointments, my test results and other matters related to my healthcare. I further understand that if I arrive more than 40 minutes late for my appointment, I might be asked to re-schedule. Dr. Fram/ Dr. Bedrood/ Dr. Sato/Dr. Dodda Notice of Privacy Practices outlines a more complete description of such uses and disclosures.

INSURANCE BENEFITS

I understand that I am responsible, prior to treatment, for inquiring with my insurance company as to the benefits of my policy for services to be provided by Dr. Fram/Dr. Bedrood/ Dr. Sato/ Dr. Nghiem.

REFRACTIONS are NOT covered by insurance and is a $75.00 charge

BILLING

Insurance billing and collection related efforts are done in office. Please direct billing questions to 310-229-1220.

RELEASE OF MEDICAL INFORMATION

I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of my medical information for the purpose of the Treatment, Health Insurance Matters (Medical Records Copies), and Healthcare Operations, by any means of communication, to Dr. Fram/Dr. Bedrood/ Dr. Sato/ Dr. Nghiem.

PATIENT MEDICAL HISTORY

I have filled my patient medical history and clipboard to the best of my knowledge.

MEDICATION RENEWAL

I understand that my medication renewal is subject to a periodic review of my health status to assess indications, side effects and to monitor therapy.

OPEN PAYMENTS DATABASE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I hereby consent to examination and treatment by Dr. Fram/Dr. Bedrood/Dr. Sato/Dr. Dodda and authorize my insurance benefits to pay directly to Advanced Vision Care, Dr. Fram/Dr. Bedrood/Dr. Sato/ Dr. Nghiem.

I agree to be fully responsible for all charges for non-covered services, including measurements for eyeglasses. (REFRACTIONS)

Name: _____

Signature: _____ Date: _____