PATIENT INFORMATION
PACIFIC EYE SPECIALISTS

BERND KUTZSCHER, MD   MICHAEL HEE, MD   ANDREA JUE, MD

NAME: Mr. Mrs. Miss Ms) ____________________________________ DATE OF BIRTH: ___/___/_____

SOC. SEC. # __________-________-________   GENDER: □ M □ F

NAME OF SPOUSE (OR RESPONSIBLE PARTY IF MINOR): ____

HOME ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: _______ ____________________ **CELL** PHONE: _______ ____________________
(Area Code) (Area Code)

BUSINESS ADDRESS: ____
(STREET) (CITY) (STATE) (ZIP)

BUSINESS PHONE: _______ __________________ OCCUPATION:_________________________
(Area Code)

E-MAIL ADDRESS____________________________ @ _______________________

EMERGENCY CONTACT: Name____________________________ Ph.#_________________________

REFERRED TO THIS OFFICE BY:____

FAMILY DOCTOR NAME/ADDRESS: ____

____

MEDICAL INSURANCE POLICY NAME (present your card): SUBSCRIBER NAME

____ _____________________________

SECONDARY INSURANCE POLICY NAME (present your card): SUBSCRIBER NAME

____ _____________________________

VISION INSURANCE SUBSCRIBER NAME AND POLICY # (or present your card):

_________________________________ _______________________________

IF ANOTHER PERSON IS SUBSCRIBER FOR ANY POLICY ABOVE: DATE OF BIRTH __________

NAME___________________________________ SOC. SEC. # ________-______-________

By signing below, I authorize my insurance benefits to be paid directly to the doctor and agree that I will be responsible for non-covered services. I authorize my physician or his agents to release any information to my insurance to process claims for my care. I also understand that I am responsible for a $25 administrative fee if I do not keep an appointment and do not inform the office of this cancellation at least 24 hours ahead of the appointment.

⇒SIGNATURE: ______________________________________ DATE: ________________

By signing below, I acknowledge that I am aware that this office (Pacific Eye Specialists) has a privacy policy that is designed to protect the privacy of my medical information and that is based on the standards of the "Health Insurance Portability and Accountability Act" (HIPAA). I understand that health care providers are allowed to use my confidential information for purposes of treatment, payment or healthcare operations including electronic prescriptions (e-Rx), and I authorize this use by Pacific Eye Specialists. I understand that a written summary of the privacy policy is available and that I may review it.

⇒SIGNATURE: ______________________________________ DATE: ________________

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- **GENERAL HEALTH**

Please mark any areas of concern about your health:

☐ Wt. Loss/Fevers	☐ Diabetes	☐ High blood pressure	☐ Lung disease
☐ Heart Attack/angina	☐ Arthritis	☐ Stroke	☐ High Cholesterol
☐ Thyroid disease	☐ Sinus disease	☐ Cancer	☐ Neurological problem
☐ Bleeding problem	☐ HIV	☐ Hepatitis	☐ TB
☐ Check if pregnant	☐ Prior severe injury	☐ Anesthesia problems	☐ Other

- **EYE HEALTH**

Have you ever had (or been told you have):

☐ Cataract	☐ Glaucoma	☐ Macular degeneration	☐ Retinal detachment
☐ Diabetic retinopathy	☐ Eye Surgery	☐ Eye trauma	☐ Other eye disease

RISK FACTORS

Smoking Status:
- ☐ **Current, daily smoker**
- ☐ **Current, sometime smoker**
- ☐ **Smoker, status unknown**
- ☐ **Never Smoker**
- ☐ **Former Smoker**
- ☐ **Other**
- ☐ **Unknown if ever smoked**

- ☐ **American Indian**
- ☐ **Asian**
- ☐ **Black**
- ☐ **Native Hawaiian**
- ☐ **Type Unknown**
- ☐ **White**

- ☐ **Hispanic Origin**
- ☐ **Non-Hispanic Origin**
- ☐ **Type Unknown**

- ☐ **English**
- ☐ **Spanish**
- ☐ **Chinese**
- ☐ **Arabic**
- ☐ **Tagalog**

- **FAMILY EYE HISTORY**

Is there any family history of:

☐ Cataract	☐ Glaucoma	☐ Macular degeneration	☐ Retinal detachment
☐ Diabetic retinopathy	☐ Eye Surgery	☐ Eye trauma	☐ Other eye disease

Detail:

- **MEDICATIONS -** Please list medications you are currently using:

- **ALLERGY TO MEDICATIONS** - Please list allergies to medications:

- **I am interested in: ☐ new glasses ☐ new contact lenses ☐ cataract surgery information ☐ Crystalens information ☐ lens implant for astigmatism ☐ laser vision correction ☐ macular degeneration information ☐ glaucoma information ☐ diabetes information ☐ dry eye information ☐ eye color changing contact lenses ☐ Botox, eyelash growth and other cosmetic information**

(Please note that you may be charged separately for a glasses or contact lens prescription if your insurance does not cover that service)