PATIENT INFORMATION

Office use PT#

Mr. Mrs. Ms. Dr. Mx. _____ SS#_____
Last Name First M.I.

Address _____ City _____ State _____ Zip _____

Home # ( ) _____ Cell # ( ) _____ ☐check if no contact via Cell#

Birth Date _____ E-mail Address _____
☐check if no contact requested via E-mail Address

Primary care doctor _____ # ( ) _____
Name City

Pharmacy _____ # ( ) _____
Name Address/City

Emergency contact _____ # ( ) _____
Name Relationship

Employer _____ Occupation _____

Address _____ Work # ( ) _____

How did you hear about us *(circle one)*?

Family/Friend * Doctor * Newspaper * Radio * Internet * Insurance List * Seminar/Health Fair

Please Specify: _____

Please present all insurance cards for copying

Primary insurance _____ ID # _____

Person who holds policy _____ DOB _____ **Relationship** _____ SS # _____

Secondary insurance _____ ID # _____

Person who holds policy _____ DOB _____ **Relationship** _____ SS # _____

Do you have vision Insurance? VSP/Metlife Davis Vision

MEDICARE PATIENTS: I,_____, request that payment of authorized Medicare benefits be made on my behalf to Aarchan R. Joshi, MD, Lawrance N. August, MD, Rindha Reddy, MD, Aditi S. Jani, MD, Erica T. Liu, MD, or Ashkan Pirouz, MD for any services furnished me. I also permit a copy of this authorization to be used in place of the original, and authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits, or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named Doctors and information regarding my Medicare claims under Title XVIII of the Social Security Act.

ALL PATIENTS: I,_____, give permisson to Aarchan R. Joshi, MD, Lawrance N. August, MD, Rindha Reddy, MD, Aditi S. Jani, MD, Erica T. Liu, MD, And Ashkan Pirouz, MD to share and necessary information with other medical entitles to facilitate my treatment either by mail, fax, phone, or other electronic means.

Signed _____ **Date** _____

Witness _____ Date _____

South Bay
Eye Institute

Aarchan Joshi, M.D.
Lawrence N. August, M.D.
OPHTHALMOLOGY
Diplomates, American Board of Ophthalmology
Fellows, American Academy of Ophthalmology

520 North Prospect Avenue • Suite 206 • Redondo Beach, California 90277 • Telephone (310) 376-8850

PATIENT DEMOGRAPHICS QUESTIONNAIRE

Name _____

RACE -- Please mark what best describes you.

- ☐ White/Caucasian
- ☐ Hispanic
- ☐ Black/African American
- ☐ Multi-racial
- ☐ **I prefer not to answer**
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian

Are you of Hispanic Origin?

- ☐ Yes
- ☐ No, not Hispanic/Latino
- ☐ **I prefer not to answer**

Please indicate your preferred spoken Language

_____

- ☐ **I prefer not to answer**

Please note: You may be asked to update this page yearly Date _____

What brings you here today? _____

Patient Name _____ **Birth Date** _____

Health History	For example:	Yes	No	Specific problem
Constitutional	(weight loss, fever, fatigue)	☐	☐	_____
Ear, Nose, Throat	(sinus, allergies, vertigo)	☐	☐	_____
Cardiovascular	(blood pressure, cholesterol, stroke)	☐	☐	_____
Respiratory	(COPD, sleep apnea, asthma)	☐	☐	_____
Gastrointestinal	(acid reflux, ulcers)	☐	☐	_____
Musculoskeletal	(arthritis, muscle/joint pain)	☐	☐	_____
Genitourinary	(prostate, bladder)	☐	☐	_____
Skin	(rosacea, rash, breast problems)	☐	☐	_____
Neurological	(headaches, migraines, seizures)	☐	☐	_____
Psychiatric	(depression, anxiety, schizophrenia)	☐	☐	_____
Endocrine	(diabetes, thyroid, hormone)	☐	☐	_____
Hematologic/Blood	(anemia, clotting, hemorrhaging)	☐	☐	_____
Allergy/Immune	(autoimmune, rheumatoid, HIV)	☐	☐	_____
Other	(cancer, hepatitis, syphilis)	☐	☐	_____

Have you been vaccinated for pneumonia (if over 65 years old)? ☐☐

Surgeries including eye surgeries (type and date) _____

_____

Social History

Alcohol use ☐ Y ☐ N _____drinks/day _____drinks/week

Tobacco use ☐ Y ☐ N _____packs/day

Recreational drugs ☐ Y ☐ N _____

Family History	Y	N	Who
Blindness	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____
Retinal detachment	☐	☐	_____
Macular degeneration	☐	☐	_____
Glaucoma	☐	☐	_____
Keratoconus	☐	☐	_____

	Y	N	Who
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart disease	☐	☐	_____
Autoimmune disease	☐	☐	_____
Hereditary disease	☐	☐	_____

Eye History	Y	N
Blindness	☐	☐
Amblyopia (lazy eye)	☐	☐
Retinal detachment	☐	☐
Macular degeneration	☐	☐
Cataracts	☐	☐
Keratoconus	☐	☐
Patching	☐	☐
Drooping eyelid	☐	☐
Eye injury	☐	☐
Eye infection	☐	☐
Styes	☐	☐
Other _____	☐	☐

Eye Symptoms	Y	N
Blurred vision	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Double vision	☐	☐
Eye pain	☐	☐
Dryness	☐	☐
Itching	☐	☐
Burning	☐	☐
Watering	☐	☐
Discharge	☐	☐
Peripheral vision loss	☐	☐
Glare/halos	☐	☐
Other _____	☐	☐

Last eye exam _____ **By** _____

Date _____

Please note: You may be asked to update this page yearly

Patient Name _____ Birth Date _____

MEDICATIONS (prescription and over-the-counter medications, including eye drops):

Name	Dose	Times per day	Date started

ALLERGIES TO MEDICATION: **Reaction:**

_____

_____

_____

_____

Are you allergic to latex? YES / NO

South Bay Eye Institute Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At South Bay Eye Institute, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information in our normal operations. For example, one of our staff will enter your information into our computer.

We may share your information with our business associates, such as a billing service. We have a written contract with each business associate which requires them to protect your privacy.

We may use your information to contact you. For example, we may send you statements, newsletters, reminder cards or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Due to changes in healthcare, we have joined the **Torrance Memorial Health System,** an ACO (Accountable Care Organization) which facilitates the secure, electronic sharing of health information among participating doctor's offices, other health providers and government agencies through HIE (Health information Exchange). This allows providers to share information in a timely manner and more effectively coordinate your care. If you choose to OPT-OUT of the HIE, please ask for the necessary paperwork.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will fax or mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in you file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Marion Andrade at (310) 376-8850.

This notice goes into effect as of April 14, 2003.

ACKNOWLEDGEMENT

I have received a copy of the South Bay Eye Institute Notice of Privacy Practices.

Signed _____ Date _____

Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

Healthcare Eligibility Waiver and Financial Responsibility

Patient Name: _____ **D.O.B**_____

The patient or patient's legal representative hereby certifies that he/she is eligible for health plan benefits coverage and has chosen the above stated physician as the provider of his/her health care.

The patient or patient's legal representative understands that he/she is responsible for any copay and/or deductible and also if patient is found ineligible for coverage or exceeding the insurance coverage, he/she is financially responsible for all costs and expenses incurred during the delivery of health services and agrees to pay these charges to the physician accordingly. Payments are due in full within 90 days of the date of serivce. As a Courtesy, our office will help you with any coverage issue that may arise, but a late fee on outstanding accounts will be imposed after 120 days of the date of service. We mail monthly statements reflecting current transactions.

Forms of payment we accept are Visa, Mastercard and Checks. Please make checks payable to Dr. Aarchan Joshi.

Any questions please contact the office at (310)376-8850. Thank you.

_____ **Initials by Office Staff**

***Please notice that there is going to be a $25.00 fee for any returned check.**

_____	_____	_____
Print Patient's Name	Patient's Signature	Date

_____	_____
Signature of Legal Representative	Relationship to Patient

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Missed appointments: We understand that emergencies may happen and you may miss your appointment unexpectedly. With less than 48 hours notice, there will be a fee of $50 for any missed appointment. Including surgery scheduled at the surgery center.

Print Name _____ Date of Birth _____

Signature _____ Date _____