



PATIENT INFORMATION

Date _____

Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Date of Birth _____ / _____ / _____ Age _____ Marital Status _____

☐ Male ☐ Female ☐ Other Preferred pronouns _____ Preferred name to be used _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

E-mail _____ Social Security # _____

Best Method of Contact (Check one) ☐ Home ☐ Cell ☐ Work ☐ Email

Employer _____ Occupation _____

List your hobbies or activities that require special visual needs _____

HOW WERE YOU REFERRED TO THIS OFFICE?

(Check one) ☐ My Eye Doctor ☐ My PCP ☐ Insurance ☐ Internet

Who is your Eye Doctor? _____ City _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Phone (_____) _____

MEDICAL/VISION INSURANCE INFORMATION (Attach copy of cards)

Insurance Company _____ Group/Policy# _____

Policy Holder _____ Member/ID# _____

Date of Birth _____ / _____ / _____ Sex _____ Relationship to Policy Holder _____

I understand that dilating drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.

Signed _____ Date _____

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DATE:** _____

Preferred pharmacy: _____

Pharmacy address: _____

List any medications you currently take (prescription and over-the-counter):

Do you have allergies to any medications? ☐ Yes ☐ No If yes, please list the medications:

EYE HISTORY

Any eye disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal tear or detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma (High eye pressure)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry eye syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent corneal erosion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amblyopia ("lazy eye")	<input type="checkbox"/> Yes <input type="checkbox"/> No	Keratoconus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any eye injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any eye dystrophy or degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any herpes infection in the eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
ALK/RK/LASIK/PRK Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any infection in the eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

If you answered yes to any of the above please explain: _____

SOCIAL HISTORY

Do you currently wear glasses? ☐ Yes ☐ No

If yes, how old is the current prescription? _____ When was your last eye exam? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes: ☐ Occasional ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Do you smoke? ☐ Yes ☐ No

If yes: ☐ Occasional ☐ 1/2 pack per day ☐ 1 pack per day ☐ 1+ pack per day

Have you ever had a blood transfusion? ☐ Yes ☐ No

MEDICAL HISTORY QUESTIONNAIRE (PAGE 2)

OVERALL HEALTH	YES	NO	DETAILS
General / Constitutional (Fever, Weight Loss, etc.)			
Ears, Nose, Throat (Stuffy Nose, Earache, Cough, Dry Mouth, etc.)			
Cardiovascular (High Blood Pressure, Racing Pulse, etc.)			
Respiratory (Congestion, Wheezing, etc.)			
Gastrointestinal (Stomach Upset, Diarrhea, Constipation, etc.)			
Genital, Kidney Bladder (Painful Urination, Frequent Urination, Impotence, etc.)			
Muscles, Bones, Joints (Joint Pain, Stiffness, Swelling, Cramps, etc.)			
Skin (Pimples, Warts, Growths, Rashes, etc.)			
Neurological (Numbness, Headache, etc.)			
Psychiatric (Anxiety, Depression, Insomnia, etc.)			
Endocrine (Diabetes, Hypothyroid, etc.)			
Blood / Lymph (Cholesterolemia, Anemia, etc.)			
Allergic / Immunologic (Sneezing, Swelling, Redness, Itching, Hives, etc.)			

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP TO PATIENT M = Mother F = Father S = Sibling G = Grandparent
Arthritis			
Blindness			
Cancer			
Diabetes			
Glaucoma			
Heart Disease or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			



Scott Grant, M.D. | Sean D. Adrean, M.D. | Ash Pirouz, M.D.
Hema Ramkumar, M.D. | Caleb Ng, M.D. | Chang Sup Lee, M.D.

NAME: _____ DATE OF BIRTH: _____

Rx History Consent

I authorize Retina Consultants of Orange County to access my prescription medical history from other healthcare providers or third party pharmacy benefit payers in order to reconcile all medications with the purpose of improving patient care, patient safety, and clinic efficiency.

I authorize Retina Consultants of Orange County to obtain my medical prescription history for the duration of two years from the date undersigned.

Patient Name

Patient Signature

Date

Patient Preferred Pharmacy

Complete pharmacy information below to indicate which pharmacy your electronic prescriptions will be sent.

Preferred Pharmacy Name

Preferred Pharmacy Phone Number

Preferred Pharmacy Address

FULLERTON: 301 W. Bastanchury Road, Suite 285, Fullerton, California 92835 | (714) 738-4620 | Fax (714) 738-0388
LOS ALAMITOS: 3771 Katella Avenue, Suite 208, Los Alamitos, California 90720 | (562) 431-7345 / Fax (562) 431-7317
WHITTIER: 6319 Greenleaf Avenue, Whittier, California 90601 | (562) 945-2468 | Fax (562) 945-8804
WEST COVINA: 1135 S. Sunset Avenue, Suite 305, West Covina, California 91790 | (626) 814-1134 / Fax (562) 945-8804



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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certificates.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of said notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name

Patient Representative

Signature

Date

Please list any family members we can release your medical information to below.

OFFICE USE ONLY

I attempted to obtain the signature of the patient's representative acknowledging receipt of the "Notice of Privacy Practices" for Retina Consultants of Orange County, Professional Corporation, but was unable to do so, as documented below.

Date	Reason	Name	Signature

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NAME: _____ DATE OF BIRTH: _____

Notice of Privacy Practices Acknowledgement

I, _____, am currently an eligible member enrolled with _____ insurance or IPA. I understand that if for any reason I am not eligible under this insurance or IPA on the dates services are rendered, I (or Guardian if minor) will be held responsible for any services provided to me.

Patient or Guardian Signature

Date

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Patient Consent for Use of Email Communication

To better serve our patient, our office has established a patient portal as a form of communication. The patient portal offers secure viewing and communication as a service to patients who wish to view part of their records and communicate with our staff and physicians. For routine matters that do not require immediate response, please feel free to contact us through the patient portal. The turnaround time for routine patient communication is within 24 hours. **Please remember however, that this form of communication is not appropriate for use in an emergency. Should you require urgent or immediate attention, please contact the office directly.**

By using our patient portal system, you will be able to go online and do the following:

- Request medication refills
- Review your medical summary, medication list, treatment history, and appointment history
- Request an appointment and appointment changes
- Communicate with office staff and physicians via secure messaging
- Allow designated family members to access your information with your consent

RESPONSIBILITIES OF PATIENT PORTAL USERS

Every authorized portal user has a responsibility to protect the confidentiality of health records. All authorized portal users are expected to keep their portal user ID and password secure to prevent any unauthorized access to patient information. Retina Consultants of Orange County is not liable for breaches of confidentiality arising from unauthorized use of such information. If you suspect that someone has learned your password, you should access the portal site immediately and change it. If you become aware of a breach, for whatever reason, of this confidentiality, you are expected to promptly report it to Retina Consultants of Orange County.

CONSENT

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for email communications to and from Retina Consultants of Orange County.

Patient Name: _____

Patient Signature: _____ Date: _____

Email Address: _____

Patient Representative (if applicable): _____

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