San Diego Retina Associates

First Name:	Last Name:	Date of birth:

What problems or symptoms are you currently having with your eye(s)?

	Rt Eye	Lt Eye		Rt Eye	Lt Eye		
□ Floaters/Spots	□	□	□ Loss of side vision	□	□	□ Trouble with colors	
□ Flashing lights	□	□	□ Eye pain	□	□	□ Poor depth perception	
□ Blurred Vision	□	□	□ Sensitivity to light/ glare	□	□		
□ Distortion/waviness	□	□	□ Other: _____			_____	

Previous Ocular History (self):

□ Retinal Detachment □ Macular Degeneration □ Glaucoma □ Cataract □ Diabetic Retinopathy

Previous Eye Surgeries:

	Rt Eye	Lt Eye		Rt Eye	Lt Eye
1. _____	□	□	2. _____	□	□

Ocular History (family, *not* including yourself): Please indicate relationship below

□ Retinal Detachment □ Macular Degeneration □ Glaucoma □ Cataract □ Diabetes

_____ _____ _____ _____ _____

Which of these condition do you have or have you been treated for in the past? (check all that apply)

□ Diabetes _____ yrs A1c _____	□ Thyroid Disease	□ Congestive Heart Failure	□ HIV Positive
□ Stroke _____ mo/yrs ago	□ Seizure Disorder	□ Arrhythmia	□ Anemia
□ T. I. A. _____ mo/yrs ago	□ Arthritis	□ Osteoporosis	
□ Heart Attack _____ mo/yrs ago	□ Asthma	□ Prior blood transfusion	
□ Emphysema	□ Angina	□ High Blood Pressure: Controlled □ Y □ N	
□ Elevated cholesterol	□ Cancer: Details _____	□ Other : _____	

Current Medications (other than eye medications) with dosage:

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

Do you have allergies to medications? □ Yes □ No If yes, please list: _____

_____

Current Eye Drops:

1. _____	□ Right Eye	□ Left Eye	____ drops	_____	times a day
2. _____	□ Right Eye	□ Left Eye	____ drops	_____	times a day
3. _____	□ Right Eye	□ Left Eye	____ drops	_____	times a day
4. _____	□ Right Eye	□ Left Eye	____ drops	_____	times a day

Social History:

Occupation: _____ Driving: □ Yes □ No License: □ Restricted □ Unrestricted

Smoking: □ Yes □ No # ___ packs a day ____ yrs Alcohol?: □ Yes □ No if yes, how much? _____

_____ _____

Patient Signature Date

San Diego Retina Associates

Mark D. Smith, M.D., F.A.C.S.
Fane L. Robinson, M.D., F.A.C.S.
Vincent Q. Nguyen, M.D., M.B.A
Bradley H. Jacobsen, M.D.
Delu Song, M.D., Ph.D.

Thank you for choosing San Diego Retina Associates as your healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's legal guardian) is ultimately the one fully financially responsible for of his/her medical care. Insurance coverage is a contract between the patient and their insurance policy. As a courtesy, a claim will be filed on your behalf for services rendered in our office to your medical insurance. The patient is required to provide us with the most current and updated insurance information. If the information provided is not correct or updated, the patient is responsible for any charges incurred.

Patients are responsible for: co-pays, coinsurance, deductibles, and all non-covered procedures. **Payment is due at the time of service**. For your convenience, we accept cash, check and most major credit cards in our office. If necessary, we provide discounts for our private paying patients.

Patients that are in the process of obtaining insurance coverage and are seen under emergency or urgent circumstances are considered **cash pay**. We will offer a **14-day grace period** for you to provide medical insurance coverage if you obtain retro-aactive coverage. We will be glad to bill you for services provided beginning your first day of eligibility.

Patient Authorizations

By my signature below, I hereby authorize San Diego Retina Associates physicians and staff to release **ALL** my medical and other information acquired through the course of my treatment to the necessary insurance companies and third-party payers.

Cancellation Policy

Please provide our office a 24-hour working day notice if you need to reschedule your appointment. Appointments are high in demand, and your early reschedule/cancellation will give another person access to medical care in a timely manner. **A "No-Show", "No-Call" or Missed appointment, without proper 24-hour working day notification, will be charged a $25 fee.** This fee is not billable to your insurance. It is your full responsibility.

As a courtesy, we make reminder calls, for appointments, one to two days in advance. Please note, if a reminder call or message is not received, the cancellation policy remains in effect.

I have read, understand and agree to the provisions in this Patient Financial Responsibility Form:

_____

Printed Name of Patient Date of Birth Printed Name of Guardian (if applicable)

_____

Signature of Patient or Guardian Date

San Diego Retina Associates

Mark D. Smith, M.D., F.A.C.S.
Fane L. Robinson, M.D., F.A.C.S.
Vincent Q. Nguyen, M.D., M.B.A
Bradley H. Jacobsen, M.D.
Delu Song, M.D., Ph.D.

INFORMATION REGARDING DILATING DROPS:

Dilating drops are used dilate or enlarge the pupil of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time and this varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected.

Because driving may be difficult immediately after a dilated eye examination, it is best if you make arrangements *not* to drive yourself.

Adverse reactions, such as acute angle closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

☐ I hereby authorize the physicians' staff to administer dilating eye drops.

☐ I understand the eye drops are necessary to diagnose my condition.

_____ _____ / _____ / _____
Patient / person authorized to sign for patient Date

_____ _____ / _____ / ____
Witness / staff Date

San Diego Retina Associates

7695 Cardinal Court, Suite 100
San Diego, CA 92123

3231 Waring Court Suite S
Oceanside, CA 92056

Patient Registration form

First Name	MI	Last Name	Sex
Home Address		City	State	Zip
Home Phone	Work Phone	Cell Phone	

Preffered method of contact for appointment or recall reminders: □ **Home phone** □ **Text** □ **Mobile phone** □ **email**

Date of Birth	Age	Social Security Number	Marital Status □ S □ M □ D □ W	E-mail address
Emergency Contact Name		Phone Number		Relationship
Patients Employer/Occupation		Financially Responsible Person		Relationship
Financially Responsible Person Address (if different)		Home Phone		Work or Cell Number
Is Patient In Skilled Nursing Facility? □ Yes □ No		Name and Address of facility		Facility Phone Number
Referring Physician Name				Phone Number
Primary Care Physician Name				Phone Number
Primary Insurance Carrier			Medical Group	
Subscriber Name		Subscriber ID		Date of Birth
Policyholder Name		Policyholder SSN		Date of Birth
Secondary Insurance Carrier			Medical Group:	
Subscriber Name		Subscriber ID		Date of Birth
Policyholder Name		Policyholder SSN		Date of Birth

I hereby authorize San Diego Retina Associates to disclose my medical and billing information to:

1. _____ _____

2. _____ _____

Please print name — Indicate relationship

☐ I hereby give authorization for payment of Medicare and/or any other insurance benefits to be made directly to San Diego Retina Associates for services rendered.

☐ I hereby authorize release of any medical information necessary to secure payment of benefit.

☐ I hereby acknowledge I have received the San Diego Retina Associates Notice of Privacy Practices.

Patient Signature (or person authorized to sign)	Relationship to patient
Printed Name:	Date:

San Diego Retina Associates

Mark D. Smith, M.D., F.A.C.S.
Fane L. Robinson, M.D., F.A.C.S.
Vincent Q. Nguyen, M.D., M.B.A
Bradley H. Jacobsen, M.D.
Delu Song, M.D., Ph.D.

Meaningful Use Defined

Meaningful use is using certified electronic health record (HER) technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped that the meaningful use compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research date on health systems

Please complete the following questions required for Meaningful Use Reporting:

Patient Name: _____ Account: _____

Ethnicity:

□ Unknown □ Hispanic or Latino □ Not Hispanic or Latino □ Declined to Specify

Race:

□ Unknown □ Asian-Region _____ □ African American □ White □ Native Hawaiian

□ Pacific Islander-Region □ Declined to Specify

Language:

□ English □ Spanish □ Vietnamese □ Tagalog □ Other (please specify) _____

Preferred method of communication:

□ Home Telephone □ Work Phone □ Cell Phone □ Email

SDRA MEDICATION LIST

Patient Name:	**Date of Birth:**
ALLERGIC TO:	
Please verify at every visit	

Name of Medication :	**Dose (mg)**	**How many times per day**										

Medical Review of Systems

Patient Name:	**Allergic To:**

Medical Review of Systems	Symptoms	Yes	No
Constitutional:	Fever		
	Fatigue		
	Night Sweats		
Ears, Nose and Throat:	Hearing Loss		
	Ear Ache		
	Sore Throat		
	Vertigo		
	Recurrent Nose Bleeds		
Respiratory:	Shortness of Breath		
	Cough		
	Coughing Blood		
Cardiovascular:	Chest Pain		
	Palpitations		
Gastrointestinal:	Vomiting		
	Diarrhea		
	Constipation		
	Abdominal Pain		
Genitourinary:	Pain with Urination		
	Difficulty Urinating		
	Blood in Urine		
Endocrine:	Cold or Heat Intolerance		
	Loss of Appetite		
	Loss of Weight		
	Excessive Weight Gain		
	Excessive Thirst		
Psychiatric:	Depression		
	Extreme Anxiety		
Neurologic:	Dizziness		
	Headaches		
	Visual Field Changes		
	Weakness		
	Numbness		
Dermatologic:	Rashes		
	Itching		
Musculoskeletal:	Back Pain		
	Joint Pain		
	Joint Stiffness		
Hematological:	Bleeding Tendency		
	Bruise Easily		
	Tiredness		
	Multiple Infections		
	Clotting Tendency		
Peripheral Vascular:	Leg pain on walking		

Patient Signature	Date: