ARMIN VISHTEH, M.D.
LASER VISION CORRECTION
MEDICAL & SURGICAL DISEASES OF THE EYE
DIPLOMATE OF THE AMERICAN BOARD OF OPHTHALMOLOGY

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell# ( )_____ Alternate #: ( ) _____ Specify: _____ E-mail_____

Would you like to be contacted via text message at the above cell number? _____

Patient's Sex: __ Male __ Female Marital Status: S M W D Social Security #: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Emergency Contact Name: _____ Phone: ( ) _____

INSURANCE INFORMATION

Primary Insurance: _____ ID Number:_____ Group#: _____

Insured Last Name: _____ First Name:_____Date of Birth:_____

SS# : _____ Relationship to Insured: _____

Secondary Insurance: _____ ID Number:_____ Group#: _____

Insured Last Name: _____ First Name:_____Date of Birth:_____

SS#: _____ Relationship to Insured: _____

REFERRAL SOURCES

How were you referred to our offices? (List as many as applicable)

_____

MEDICAL HISTORY QUESTIONNAIRE

Primary reason for today's visit: _____

REVIEW OF SYSTEMS
Do you currently have any of the following problems? If "YES", please explain.

EYES	YES	NO	EXPLANATION OF PROBLEM
Loss or blurred vision	( )	( )	_____
Loss of side vision, double vision	( )	( )	_____
Itching , burning, or discharge	( )	( )	_____
Redness	( )	( )	_____
Gritty feeling, dryness or tearing	( )	( )	_____
Glare/light sensitivity, or halos	( )	( )	_____

Eye pain or soreness	( )	( )	_____
Do you currently wear contacts?	( )	( )	_____
Are you having problems with contacts?	( )	( )	_____

Vision causes problems with: ❑ Driving ❑ Night Vision ❑ Reading ❑ Sports/Outdoor Activities

History of cataracts	( )	( )	_____
History of glaucoma	( )	( )	_____
History of crossed/lazy eye(s)	( )	( )	_____
Eye injury or other disease	( )	( )	_____
Eye surgery	( )	( )	_____

GENERAL

Ear, nose, mouth, throat	( )	( )	_____
Cardiovascular, (heart, blood vessels)	( )	( )	_____
Respiratory (lungs/breathing)	( )	( )	_____
Gastrointestinal (stomach/intestines)	( )	( )	_____
Genitourinary (genitals/kidney/ bladder)	( )	( )	_____
Musculoskeletal (muscles/joints)	( )	( )	_____
Integument (skin/breast)	( )	( )	_____
Neurological	( )	( )	_____
Psychiatric	( )	( )	_____
Endocrine (hormones, glands)	( )	( )	_____
Hematologic/Immunologic	( )	( )	_____
Seasonal Allergies	( )	( )	_____

List any medications (including any eyedrops) that you are currently using: _____
_____

List all major illnesses: Diabetes _____ Hypertension _____ Other: _____

List any major surgical procedures: _____

LIST ANY **ALLERGIES TO MEDICATION**: _____

SOCIAL HISTORY

Do you drink alcohol?	( )	( )	How much, how often ?_____
Do you smoke?	( )	( )	
Are you pregnant?	( )	( )	
Are you nursing?	( )	( )	
Have you ever had contact with a person who had a sexually transmitted disease?	( )	( )	_____

FAMILY HISTORY	**YES**	**NO**	**EXPLANATION/RELATIONSHIP**
OCULAR			
Blindness	( )	( )	_____
Cataract	( )	( )	_____
Glaucoma	( )	( )	_____
Macular Degeneration	( )	( )	_____
Retinal detachment	( )	( )	_____
MEDICAL			
Diabetes	( )	( )	_____
Arthritis, lupus, etc.	( )	( )	_____
Other (list)	( )	( )	_____

AUTHORIZATION AND RELEASE OF INFORMATION

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient or Parent of Minor Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____(printed name of patient or personal representative) acknowledge that Armin Vishteh, M.D., P.C.: has provided a written copy of its Notice of Privacy Practices for Protected Health Information to (check one) □ myself or □ specify:_____ (If signing as a personal representative, documentation of your legal right to do so must be provided)

_____	___/___/____	_____	_____
Signature of Patient or Personal Representative	Date (mm/dd/yyyy)	Printed Name	Relationship to patient (if not self)

To be completed by Armin Vishteh, M.D., P.C.

□ We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reasons:

_____

_____

_____

Printed Name: Signature: