



**GLAUCOMA  
CENTER OF  
SAN FRANCISCO**

55 Stevenson Street  
San Francisco, CA 94105  
Tel: (415) 981-2020  
Fax: (415) 981-2019  
frontdesk@glaucomasf.com  
www.glaucomasf.com

Andrew G. Iwach, M.D.  
Shan C. Lin, M.D.  
Terri Pickering, M.D.  
Sunita Radhakrishnan, M.D.  
Sophia Hsiao, O.D.

Emeritus  
H. Dunbar Hoskins, Jr., M.D.  
Robert N. Shaffer, M.D.,  
1912-2007  
John Hetherington, Jr., M.D.,  
1930-2020

## PATIENT REGISTRATION

### PATIENT INFORMATION

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Preferred:  Home  Cell  Work

E-Mail Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

Referred By: \_\_\_\_\_

### PHARMACY INFORMATION

Preferred Pharmacy: \_\_\_\_\_  Mail Order Pharmacy

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### INSURANCE INFORMATION (please give insurance cards to receptionist to copy)

I certify that I (or my dependent) have insurance coverage as stated provided to the office. I authorize the release of any medical information necessary to process all claims and agree to have insurance payments made directly to Glaucoma Center of San Francisco to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date



**GLAUCOMA  
CENTER OF  
SAN FRANCISCO**

55 Stevenson Street  
San Francisco, CA 94105  
Tel: (415) 981-2020  
Fax: (415) 981-2019  
frontdesk@glaucomasf.com  
www.glaucomasf.com

Andrew G. Iwach, M.D.  
Shan C. Lin, M.D.  
Terri Pickering, M.D.  
Sunita Radhakrishnan, M.D.  
Sophia Hsiao, O.D.

Emeritus  
H. Dunbar Hoskins, Jr., M.D.  
Robert N. Shaffer, M.D.,  
1912-2007  
John Hetherington, Jr., M.D.,  
1930-2020

## MEDICAL QUESTIONNAIRE

### OCULAR HEALTH HISTORY

Previous Eye Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Do you wear glasses?  Yes  No For:  Distance  Near  As Needed

Do you wear contact lenses?  Yes  No Type: \_\_\_\_\_

**EYE MEDICATIONS:** List any eye medications you are currently using, including over the counter

\_\_\_\_\_

\_\_\_\_\_

**EYE SYMPTOMS:** Please mark all that currently apply

- Blurred Vision – Distance
- Blurred Vision – Near
- Burning / Stinging Eyes
- Discharge from Eyes
- Double Vision
- Dry Eyes
- Eye Strain
- Flashing Lights
- Floaters

No eye symptoms

- Halos
- Itching Eyes
- Light Sensitivity
- Loss of Vision
- Poor Night Vision
- Red Eyes
- Temporary Loss of Vision
- Twitching Eyelid
- Watery Eyes

**EYE HISTORY:** Please mark all that apply

Yourself Family

- Glaucoma
- Cataracts
- Crossed Eyes / Strabismus
- Macular Degeneration
- Retinal Detachment
- Blindness
- Eye Injury

Yourself Family

No history of eye problems

- Glaucoma Suspect
- Iritis
- Lazy Eye / Amblyopia
- Diabetic Retinopathy
- Retinal Disease
- Color Deficiency
- Eye Infection

Please explain any marked above: \_\_\_\_\_

Other: \_\_\_\_\_

**EYE SURGERIES:** Please mark all that apply

R L

- Glaucoma Surgery
- Corneal Transplant
- Retina Surgery

R L

- Glaucoma Laser
- LASIK / PRK / RK
- Retina Laser

No prior ocular surgery

R L

- Cataract Surgery
- Eye Muscle Surgery
- Vitrectomy

Please explain any surgeries marked above: \_\_\_\_\_

Other Eye Surgeries: \_\_\_\_\_



**GLAUCOMA  
CENTER OF  
SAN FRANCISCO**

55 Stevenson Street  
San Francisco, CA 94105  
Tel: (415) 981-2020  
Fax: (415) 981-2019  
frontdesk@glaucomasf.com  
www.glaucomasf.com

Andrew G. Iwach, M.D.  
Shan C. Lin, M.D.  
Terri Pickering, M.D.  
Sunita Radhakrishnan, M.D.  
Sophia Hsiao, O.D.

**Emeritus**  
H. Dunbar Hoskins, Jr., M.D.  
Robert N. Shaffer, M.D.,  
1912-2007  
John Hetherington, Jr., M.D.,  
1930-2020

**MEDICAL HEALTH HISTORY**

Primary Care Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**MEDICATIONS:** List any medications you are currently using  None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** List any allergies you have to medications or other substances  None

\_\_\_\_\_  
\_\_\_\_\_

**GENERAL HEALTH:** Please mark all that apply  No history of illnesses

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies              | <input type="checkbox"/> HIV Positive         |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Liver Disease        |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Lung Disease         |
| <input type="checkbox"/> Bleeding Disorder      | <input type="checkbox"/> Lupus                |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Migraine Headaches   |
| <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Neurologic Disease   |
| <input type="checkbox"/> Diabetes (Type ____)   | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Hearing Loss           | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Heart Condition        | <input type="checkbox"/> Skin Conditions      |
| <input type="checkbox"/> Hepatitis (Type ____)  | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Thyroid Conditions   |
| <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Tuberculosis         |

Please explain any marked above: \_\_\_\_\_

Other: \_\_\_\_\_

Are you pregnant?  Yes  No

**GENERAL SURGERIES:** List any surgeries you have had  None

\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Current Occupation: \_\_\_\_\_

Tobacco Use:  Yes  No If yes, how much and how often? \_\_\_\_\_

Alcohol Use:  Yes  No If yes, how much and how often? \_\_\_\_\_



55 Stevenson Street  
San Francisco, CA 94105  
Tel: (415) 981-2020  
Fax: (415) 981-2019  
frontdesk@glaucomasf.com  
www.glaucomasf.com

Andrew G. Iwach, M.D.  
Shan C. Lin, M.D.  
Terri Pickering, M.D.  
Sunita Radhakrishnan, M.D.  
Sophia Hsiao, O.D.

**Emeritus**  
H. Dunbar Hoskins, Jr., M.D.  
Robert N. Shaffer, M.D.,  
1912-2007  
John Hetherington, Jr., M.D.,  
1930-2020

## INFORMED CONSENT FOR DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils 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, which 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 an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, 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 doctor and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

\_\_\_\_\_  
Patient's Name (please print)

X \_\_\_\_\_  
Patient Signature (or person authorized to sign for patient)      Date

X \_\_\_\_\_  
Witness Signature      Date



55 Stevenson Street  
 San Francisco, CA 94105  
 Tel: (415) 981-2020  
 Fax: (415) 981-2019  
 frontdesk@glaucomasf.com  
 www.glaucomasf.com

Andrew G. Iwach, M.D.  
 Shan C. Lin, M.D.  
 Terri Pickering, M.D.  
 Sunita Radhakrishnan, M.D.  
 Sophia Hsiao, O.D.

Emeritus  
 H. Dunbar Hoskins, Jr., M.D.  
 Robert N. Shaffer, M.D.,  
 1912-2007  
 John Hetherington, Jr., M.D.,  
 1930-2020

## PATIENT E-MAIL PERMISSION

Glaucoma Center of San Francisco offers its patients the ability to communicate with healthcare providers via electronic mail (e-mail) over the Internet.

If you would like to take advantage of this service, please observe the following:

### E-mail Rules:

1. E-mail may be used for requesting information and for asking non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please call 911 or visit the nearest Emergency Department.
2. E-mail messages may not be confidential.
  - Do not use e-mail to send or request very sensitive information without encryption. Glaucoma Center of San Francisco cannot and does not guarantee the confidentiality of any messages being sent over the Internet.
  - Messages can be misdirected or intercepted by unintended parties.
  - Patients who want e-mail sent to work addresses must recognize that employers may have the right to monitor their e-mail.
  - Your healthcare provider may ask a nurse or other provider to assist with email volume or response.
  - We will not respond to communications that are considered obscene or harassing.
3. Your healthcare provider will document e-mail communications in your medical record- either by placing a copy of the message in your record, or by summarizing the message in a written note.

### Sending E-mail:

Please be sure to include the following information in the body of every e-mail message that you send to your healthcare provider:

- Your full name
- Your birth date

If you do not provide this information, your healthcare provider may not be able to respond. In order to protect your confidentiality, do not place name, date of birth or medical record number in subject line.

If a message is ever returned because of a "bad address," please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address the healthcare provider provided, please call the healthcare provider's office to verify you have the correct address and that the e-mail system is functioning properly.

If your healthcare provider does not answer your e-mail in what you consider to be reasonable period of time, please call his or her office. Your healthcare provider may be out of the office or we could be experiencing a technical problem and unable to respond to e-mail. We cannot guarantee a particular response time.

I agree to not use or forward my health care provider's e-mail for purposes other than communication with me about my health care.

I understand and agree to the terms outlined in this document. After reading the rules and guidelines of communicating via e-mail, I still wish e-mail to be one of my preferred methods of communication with my healthcare providers.

_____	_____
Patient's Name (Printed)	Date
_____	_____
Patient <u>or</u> Legal Representative Signature	Relationship to Patient



55 Stevenson Street  
 San Francisco, CA 94105  
 Tel: (415) 981-2020  
 Fax: (415) 981-2019  
 frontdesk@glaucomasf.com  
 www.glaucomasf.com

Andrew G. Iwach, M.D.  
 Shan C. Lin, M.D.  
 Terri Pickering, M.D.  
 Sunita Radhakrishnan, M.D.  
 Sophia Hsiao, O.D.

Emeritus  
 H. Dunbar Hoskins, Jr., M.D.  
 Robert N. Shaffer, M.D.,  
 1912-2007  
 John Hetherington, Jr., M.D.,  
 1930-2020

## INSURANCE AND SELF-PAY DISCLAIMER

**Patients without Health Insurance Coverage**

As a patient without health insurance coverage I, \_\_\_\_\_, understand that I am considered a Self-Pay patient. As such, I understand that I am not being denied necessary medical care and I will be asked on the day of my visit to pay in full the charges incurred from my visit. Should I be unable to do so, a bill will be sent to me in the mail.

\_\_\_\_\_  
 Patient Signature Date

**Patients with Non-Participating Health Insurance Coverage**

I, \_\_\_\_\_, have been informed that the Glaucoma Center of San Francisco and its physicians are not on the participating panel for my insurance carrier and understand that I am considered a Self-Pay patient. As such, I understand that I am not being denied necessary medical care and I will be asked on the day of my visit to pay in full the charges incurred from my visit. Should I be unable to do so, a bill will be sent to me in the mail.

\_\_\_\_\_  
 Patient Signature Date

**Patients without Proof of Health Insurance Coverage**

As a patient without a health insurance card to prove my health insurance coverage I, \_\_\_\_\_, understand that I am considered a Self-Pay patient. As such, I understand that I am not being denied necessary medical care and I will be asked on the day of my visit to pay in full the charges incurred from my visit. Should I be unable to do so, a bill will be sent to me in the mail. Once I have presented proof of coverage in the form of an insurance card and the charges have been paid by my insurance company, I will be reimbursed by the Glaucoma Center of San Francisco.

\_\_\_\_\_  
 Patient Signature Date

**Patients with Health Insurance Coverage Needing Verification**

I, \_\_\_\_\_, understand that the health insurance plan that I have presented to the Glaucoma Center of San Francisco will be billed on my behalf, but may not be accepted, and consequently not cover the charges incurred for my visit. Should that be the case, I understand that I will be considered a Self-Pay patient and, as such, will be billed in full for the charges incurred from my visit. I further understand that I am responsible for all charges due to copays and deductibles.

\_\_\_\_\_  
 Patient Signature Date



GLAUCOMA  
CENTER OF  
SAN FRANCISCO

55 Stevenson Street  
San Francisco, CA 94105  
Tel: (415) 981-2020  
Fax: (415) 981-2019  
frontdesk@glaucomasf.com  
www.glaucomasf.com

Andrew G. Iwach, M.D.  
Shan C. Lin, M.D.  
Terri Pickering, M.D.  
Sunita Radhakrishnan, M.D.  
Sophia Hsiao, O.D.

Emeritus  
H. Dunbar Hoskins, Jr., M.D.  
Robert N. Shaffer, M.D.,  
1912-2007  
John Hetherington, Jr., M.D.,  
1930-2020

## AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: \_\_\_\_\_

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

Yes  No Home Phone: \_\_\_\_\_

Yes  No Cell Phone: \_\_\_\_\_

May we contact you at your place of employment?  Yes  No

If so, may we leave a message?  Yes  No

If yes: Work Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

Yes  No If yes, please provide:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

Is this person your Power of Attorney for medical purposes?  Yes  No

If no, please provide your Power of Attorney for medical purposes if applicable:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

**I have reviewed the Notice of HIPAA Privacy Policy provided and consent to use and disclosure of protected health information about myself for treatment, payment, and health care operations.** A copy of this policy will be provided to me upon request.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

WITNESSED BY: \_\_\_\_\_