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

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

Emeritus
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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

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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 ☐ No eye symptoms

- ☐ Blurred Vision – Distance
- ☐ Blurred Vision – Near
- ☐ Burning / Stinging Eyes
- ☐ Discharge from Eyes
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Strain
- ☐ Flashing Lights
- ☐ Floaters
- ☐ 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 ☐ No history of eye problems

Yourself	Family		Yourself	Family	
☐	☐	Glaucoma	☐	☐	Glaucoma Suspect
☐	☐	Cataracts	☐	☐	Iritis
☐	☐	Crossed Eyes / Strabismus	☐	☐	Lazy Eye / Amblyopia
☐	☐	Macular Degeneration	☐	☐	Diabetic Retinopathy
☐	☐	Retinal Detachment	☐	☐	Retinal Disease
☐	☐	Blindness	☐	☐	Color Deficiency
☐	☐	Eye Injury	☐	☐	Eye Infection

Please explain any marked above: _____

_____

Other: _____

EYE SURGERIES: Please mark all that apply ☐ No prior ocular surgery

R	L		R	L		R	L	
☐	☐	Glaucoma Surgery	☐	☐	Glaucoma Laser	☐	☐	Cataract Surgery
☐	☐	Corneal Transplant	☐	☐	LASIK / PRK / RK	☐	☐	Eye Muscle Surgery
☐	☐	Retina Surgery	☐	☐	Retina Laser	☐	☐	Vitrectomy

Please explain any surgeries marked above: _____

_____

Other Eye Surgeries: _____

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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

- ☐ Allergies
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes (Type ____)
- ☐ Hearing Loss
- ☐ Heart Condition
- ☐ Hepatitis (Type ____)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Neurologic Disease
- ☐ Pacemaker
- ☐ Psychiatric Disorder
- ☐ Skin Conditions
- ☐ Stroke
- ☐ Thyroid Conditions
- ☐ 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? _____

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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

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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 to 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 or Legal Representative Signature	Relationship to Patient

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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

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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: _____

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OPEN PAYMENTS DATABASE NOTICE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

_____ _____

Patient's Name (Printed) Date

_____ _____

Patient Signature (Legally Responsible if applicable) Relationship to Patient