

Northern California Retina---Vitreous Associates Medical Group, Inc.
Patient Registration

Last name: _____

First name: _____

Preferred name: _____

Middle name: _____ Suffix: _____

Former last name: _____

Sex: Male Female

DOB: _____

Social Security #: _____

Address: _____

Address (continued): _____

Zip Code: _____

City: _____

State: _____

Home phone: () - None

Mobile phone: () - None

Work phone: () - None

Email: _____ None

Contact Preference: Home Work Mobile Mail

Language: _____ Decline

Race: _____ Decline

Ethnicity: _____ Decline

Marital Status: Married Divorced Widowed
 Single Separated Partner

Referring Doctor: _____

Primary Care Provider: _____

Primary Insurance: _____

Address (Street): _____

Address (City, State, Zip): _____

ID #: _____

Group #: _____

Subscriber Name: _____

Subscriber DOB: _____

Subscriber SSN: _____

Secondary Insurance: _____

Address (Street): _____

Address (City, State, Zip): _____

ID #: _____

Group #: _____

Subscriber Name: _____

Subscriber DOB: _____

Subscriber SSN: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Please Read and Sign the Consent for Use and/or Disclosure of Information Form on reverse side of this form 

Northern California Retina-Vitreous Associates Medical Group, Inc.

Consent for Use and/or Disclosure of Information:

I hereby give consent to Northern California Retina-Vitreous Associates Medical Group, Inc. to use and disclose my protected health information for the purpose of treatment, payment and health care operations. I also understand that my insurance carrier may require an authorization from my primary care physician or general ophthalmologist in order to approve this visit for payment. I understand that I will be financially responsible for all charges incurred at the time of visit should that authorization be denied. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to change the terms of our Notice of Privacy Practices. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this request.

Print Name: _____

Date: _____

Signature: _____

If you are signing as the patient's representative:

I authorize the release of medical information on my behalf to those listed below:

Name: _____ Relationship: _____ Initial: _____

Name: _____ Relationship: _____ Initial: _____

You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request to the address below:

Northern California Retina-Vitreous Associates Medical Group, Inc.
Attention: Privacy Officer
2485 Hospital Drive, Suite 200
Mountain View, CA 94040

**MEDICAL HISTORY
& REVIEW OF SYSTEMS**

NAME: _____ DATE: _____

Please check all boxes that apply to you.

Endocrine Problems: None

- Diabetes
- Thyroid Disorder
- Other _____

Cardiovascular Problems: None

- High Blood Pressure
- Heart Attack or Chest Pain (Angina)
- Abnormal Heart Beat
- Heart Failure
- Angioplasty or Heart Surgery
- Other _____

Respiratory Problems: None

- Shortness of Breath
- Coughing
- Asthma/Emphysema/Chronic Obst. Pulm. Dz.
- Other _____

Head/Ear/Nose/Throat Problems: None

- Headaches/Tender Scalp/Jaw Pain/Stiff Neck
- Hearing Loss
- Other _____

Digestive Problems: None

- Reflux
- Constipation/Diarrhea
- Other _____

Genitourinary Problems: None

- Dialysis or Kidney Failure
- Sexually Transmitted Disease
- Other _____

Musculoskeletal Problems: None

- Osteo Arthritis or Rheumatoid Arthritis
- Migratory or Moving Joint Pains
- Lower Back Pains
- Other _____

Neurologic/Psychiatric Problems: None

- Stroke or Transient Ischemic Attacks
- Mood Disorder: Depression/Anxiety/etc.
- Other _____

Skin Problems: None

- Rashes
- Sores in Mouth or Genitals
- Other _____

Cancer: None

- Type/s: _____
- _____
- _____

Blood/Immune Problems: None

- Bleeding or Clotting Problems
- Auto-immune Disease _____
- AIDS/HIV
- Anemia
- Other _____

Constitutional Symptoms: None

- Fever
- Fatigue
- Unexpected Weight Loss or Gain

"Family" Eye History (Other than You): None

- Macular Degeneration
- Retinal Tears or Detachments
- Glaucoma
- Other _____

Social History: None

- Live Alone
- Live with (relationship) _____
- Retired
- Occupation _____

Habits: None

- Tobacco use _____
- Alcohol use _____
- Street Drug use _____
- Herbal/Vitamin Supplements _____
- _____
- _____

Surgeries: None

- _____
- _____
- _____
- _____

Please bring all of your medications, supplements and eye drops or a complete list of them with you to your appointment.

_____ M.D.

Northern California Retina-Vitreous Associates

MEDICATION & ALLERGY LIST

Patient Name: _____ **DOB:** _____

Please list all **Eye Drops** you are taking:

Name	Right / Left / Both Eyes?	Frequency

Please list all **Medicines, Insulin, Blood Thinners, Vitamins, & Supplements** you are taking:

Name	Dose	Frequency

ALLERGIES

24 Hour Cancellation & “No Show” Fee Policy

Recognizing that everyone’s time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment, patient care may be compromised. Without providing proper notice, other patients are prevented from receiving proper care. Therefore, the Physicians of Northern California Retina Vitreous Associates will charge a fee of \$50.00 for each missed (No Show) appointment which, absent a compelling reason, is not cancelled with a 24-hour advance notice.

“No Show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple “No Shows” in any 12 month period will result in termination from our practice.

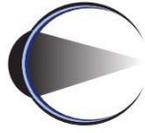
Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy

Printed, Last Name, First

Date

Signature



AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

 Name of Person/Organization Releasing Information

 Address _____ City / State / Zip _____

 Phone Number // Fax Number

To Release my Information To:

 Name of Person/Organization Receiving Information

 Address _____ City / State / Zip _____

 Phone Number // Fax Number

INFORMATION TO BE RELEASED:

- Complete Medical Record
- Medical Records for Specific Dates of Service (please list) from _____ to _____
- Other (please list) _____

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____
 Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

 Description of Personal Representative's Authority (attach necessary documentation)

Date Sent: _____ **By:** _____ **Via:** _____