Welcome To Our Office
Robert A. Hoffman O.D
Lianne C. Inouye O.D.

Patient Information

PLEASE PRINT   Date: _______________

Name: ____

Address: ______________________________________

City: ________________ **State:**______ **Zip** __________

Date of Birth: _________________

Telephone: Home: ______________________________

Work: ______________________________

Cell: _______________________________

Email: ____

Communication Preferred: HOME CELL WORK
Circle all that apply

Who may we thank for referring you?______________

Employer: ____________________________________

Occupation: __________________________________

Name of Spouse: _______________________________

Acknowledgment of Receipt of Privacy Practices

2390 E. Bidwell Suite #400
Folsom, CA. 95630
Phone:(916) 983-6211 Fax:(916) 983-6211

Signing this document signifies that you have received a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. The notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the **Notice Of Privacy Practices.**

______________________________ ________________
Signature **Date**

If signing as a personal representative of a patient, describe the relation to the patient and the source of authority to sign this form:

____
Relationship to Patient **Print Name**

____
Source of Authority

Insurance Information

Subscriber Name: __________________________________

Subscriber's Employer: ____________________________
Date of Birth: _________________________
last 4 of SS#: __________________________
Identification #: _______________________
Relationship to Patient: ____________________________

Vision Insurance: Please Circle:
VSP MES EyeMed Superior Davis
Spectera/Optum Other: ________________

Our Payment Policy

1. Payment in full is due at the time of Services
2. A $25 service charge on all returned checks.
3 Insurance Policy: Regardless of any insurance coverage, the total balance due is the legal responsibility of the patient. Payment not received with in 60 days will be the patient's responsibility.
4. I have read and understand the above policies.

Signature: ______________________________________

Medicare Authorization

I request that payment of authorized medicare benefits be made to me or on my behalf to Robert A. Hoffman / Lianne C. Inouye offices for any and all services.
To the extend permitted by law, I authorize any holder of medical or other information about me to be released to the Center for Medicare Services and their agents (any related information to determine these benefits will be provided).

____ ____
Signature of Beneficiary, Guardian or Representative: Please print name of beneficiary, Guardian or Representative

Patient Medical and Eye History

What is the purpose of today's visit? ______________________________ Date of Last Medical Exam: ____________________

List any Major Surgeries: ______________________________ Date of Last Eye Exam: ____________________

______________________________ Are you pregnant or nursing: **YES NO**

Allergies to Medications: **YES NO**	Currently taking Medications: **YES NO**
If yes, please list: ______________________________	If yes, please list: ______________________________

Do you currently have or have you had any of the following:

Blurred Vision	NO	YES
Loss of Vision	NO	YES
Distorted Vision	NO	YES
Loss of side Vision	NO	YES
Double Vision	NO	YES
Red Eyes	NO	YES
Dry Eyes	NO	YES
Mucous discharge	NO	YES
Sandy or gritty feeling:	NO	YES
Itchy eyes	NO	YES
Foreign body sensation	NO	YES

Do you currently have or have you had any of the following:

Eye Pain	NO	YES
Chronic eyelid infections:	NO	YES
Styes or Chalazion	NO	YES
Light flashes	NO	YES
Tired eyes	NO	YES
Thyroid disease	NO	YES
Allergies or hay fever	NO	YES
Chronic cough	NO	YES
Dry mouth	NO	YES
Asthma	NO	YES
Chronic bronchitis	NO	YES

Do you currently have or have you had any of the following:

Emphysema	NO	YES
Diabetes	NO	YES
Heart disease	NO	YES
High blood pressure	NO	YES
Vascular disease	NO	YES
Diarrhea or constipation	NO	YES
Kidney or bladder disease	NO	YES
Rheumatoid arthritis	NO	YES
Joint pain	NO	YES
Bleeding problems	NO	YES
Depression or anxiety	NO	YES

Please list family history for the following conditions:

			Relationship
Cataracts	YES	NO	____________
Glaucoma	YES	NO	____________
Macular Degeneration	YES	NO	____________
Retinal Detachment	YES	NO	____________
Crossed eyes	YES	NO	____________
Blindness	YES	NO	____________
Arthritis	YES	NO	____________
Lupus	YES	NO	____________

			Relationship
Diabetes	YES	NO	____________
Cancer	YES	NO	____________
Heart Disease	YES	NO	____________
High Blood Pressure	YES	NO	____________
Thyroid disease	YES	NO	____________

Other: ______________________________

Do you currently use or have you ever used any of the following:

Tobacco products	YES	NO
Alcohol	YES	NO
Illegal Drugs	YES	NO

Other: ______________________________

Would you like to talk to the doctor concerning these issues?
YES NO

Have you been exposed to or infected with any of the following:

Gonorrhea	YES	NO
Hepatitis	YES	NO
Syphilis	YES	NO
HIV	YES	NO

Would you like to talk to the doctor concerning these issues?
YES NO

Have you had any previous eye surgery? NO YES____________ Have you had any previous eye injuries____________

Previously had your eyes dilated? NO YES ____________ If yes, any significant side effects? ____________

Do you have blurred vision? NO YES ____________ If yes, distance: (circle) FAR CLOSE BOTH

Do you currently wear contacts? NO YES ____________ If yes, what brand reason:____________

Attestation

I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand that I am financially responsible for any service considered non-covered, any deductibles and/or co-payments as well as any service denied due to non-participating provider.

______________________________ ______________________________
Patient/Parent/Guardian Signature Date