CALIFORNIA
Eye Surgeons

Patient Name: _____ Date of Birth:_____

Gender: ❑Male ❑Female

Address: _____

City: _____ State: ____ Zip:_____

Home Phone: _____ Mobile Phone: _____

Email: _____

Primary Insured Name: _____ Date of Birth :_____

Relationship to patient: _____

Emergency Contact Name: _____ Phone number: _____

Relationship to patient: _____

Primary Care Physician: _____

Pharmacy name and location: _____

How did you hear about our clinic?

❑Referred by doctor: _____

❑Yelp ❑Google search ❑Walked-by the office

❑Medical doctor review website (Healthgrades.com, Vitals.com)

❑Friend/Family/Other: _____

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.**
2. **In order to control your cost of billing, we request that your office visit charges be paid at the conclusion of each visit, unless you are covered by Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services Administration, its agents or any insurance carrier I may have, any information needed to determine these benefits these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release all information necessary to secure the payment.
5. I grant permission for Kaur Eye Institute to view my prescription history from external sources.

Signature:_____ **Date**_____

(Patient or Legal Representative)

Name (if not patient): _____ Relationship to patient: _____

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California Eye Surgeons . www.CalEyes.com

5330 Camden Avenue, San Jose, CA 95124 – Tel: 408-940-3930

7652 Monterey Street, Ste B, Gilroy, CA 95020 – Tel: 408-842-2500

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Pediatric Medical History

Patient Name: _____ Date of Birth: _____

** The following information is required by the Center of Medicare and Medicaid Services. Your answer will never affect your care.*

***Race**: [ ] White [ ] Black/ African- American [ ] Asian
[ ] Pacific Islander [ ] American Indian/ Eskimo [ ] Other: _____
***Ethnicity:** [ ] non-Hispanic [ ] Hispanic

***Language**: _____

REVIEW OF SYSTEMS

WHAT IS THE PRIMARY REASON FOR TODAY'S VISIT? _____
ANY ALLERGIES TO MEDICATIONS _____

Does your child presently have any problems in the following areas? If "YES", please give an explanation.

EYES	YES	NO	EXPLANATION OF PROBLEM
• Loss or blurred vision	____	____	_____
• Loss of side/peripheral vision	____	____	_____
• Double vision	____	____	_____
• Itching	____	____	_____
• Burning	____	____	_____
• Redness	____	____	_____
• Discharge	____	____	_____
• Dryness	____	____	_____
• Tearing	____	____	_____
• Light sensitive, halos	____	____	_____
• Eye pain or soreness	____	____	_____
Ears, nose, mouth, throat	____	____	_____
Cardiovascular (heart, blood vessels)	____	____	_____
Respiratory (lungs, breathing)	____	____	_____
Gastrointestinal (stomach/intestines)	____	____	_____
Genitourinary (genitals,kidneys,bladder)	____	____	_____
Musculoskeletal (muscles, joints)	____	____	_____
Integument (skin)	____	____	_____
Neurological	____	____	_____
Psychiatric	____	____	_____

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Endocrine (hormones, glands) ____ ____ _____
Hemotologic/immunologic (blood) ____ ____ _____

Any Eye drops currently in use? _____

Any Medications currently in use? _____

Was your child born at term? _____

Any complications during pregnancy or delivery? _____

_____

Any major illnesses?_____

Any major surgical procedures?_____

FAMILY HISTORY

FAMILY OCULAR	YES	NO	RELATIONSHIP TO PATIENT
• Blindness	____	____	_____
• Cataract	____	____	_____
• Glaucoma	____	____	_____
• Macular Degeneration	____	____	_____
• Retinal Detachment	____	____	_____
• Strabismus (cross-eyes, wandering eye)	____	____	_____
• Amblyopia (lazy eye)	____	____	_____

FAMILY MEDICAL HISTORY

- Diabetes ____ ____ _____
- Arthritis ____ ____ _____
- OTHER _____
  (Medical illnesses in the family)

PATIENT SOCIAL HISTORY

- Who does your child live with? _____
- Does your child attend daycare / preschool / school? (please circle)

  If so, what grade? _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the California Eye Surgeons ("CES") Notice of Privacy Practices ("Notice"):

- It tells me how CES will use my health information for the purposes of my treatment, payment of my treatment, and health care operations of CES.
- The Notice explains in more detail how CES may use and share my health information for other than treatment, payment, and health care operations.
- CES will also use and share my health information as required/permitted by law.
- I consent to CES using and disclosing my treatment records maintained by CES for the purposes detailed in CES's Notice of Privacy Practices.

Patient's Complete Legal Name:

_____
(Please print)

Patient's DOB: _____

Signature: _____ Date: _____

(Patient or legal representative*)
*May be required to show proof of representative status

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