TULI EYE CARE CENTER

2601 W. ALAMEDA AVE. SUITE 206
BURBANK, CA 91505

TODAY'S DATE:_____ UPDATED:_____

PATIENT:_____
LAST NAME FIRST NAME MIDDLE INITIAL

HOME TELEPHONE:_____ MOBILE PONE:_____ WORK TELEPHONE:_____

ADDRESS:_____ SP-APT#:_____

CITY, STATE, ZIP:_____

E-MAIL ADDRESS:_____

SEX:_____ MARITAL STATUS:_____ PRIOR NAME:_____

PATIENT'S SOCIAL SECURITY NO:_____ DATE OF BIRTH_____ AGE_____

DO YOU AUTHORIZE RELEASE OF PERSONAL INFORMATION? YES____ NO____ MEDICAL____ BILLING_____
*(IF **YES**, PLEASE CHECK)*

AUTHORIZED PERSON:_____

HOW DID YOU HEAR ABOUT US? DOCTOR___ FRIEND___ INSURANCE___ PHONE BOOK___

OTHER SERVICES OFFERED: LASIK___ EYELID SURGERY___ BOTOX___ RESTYLANE___
(CHECK FOR MORE INFOR)

REFERRING/PRIMARY DR._____

PRIMARY INSURANCE COMPANY_____

ID#_____

SECONDARY INSURANCE COMPANY_____

ID#_____

MEDICARE#_____ MEDI-CAL#_____ARE YOU A MEMBER OF A: HMO____ PPO____

IS THIS A WORKERS' COMPENSATION:YES___NO___DO YOU HAVE A FLEXIBLE SPENDING ACCOUNT?YES__NO___

NAME OF EMPLOYER:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____ EMPLOYER'S PHONE # _____

WHO DO WE CONTACT IN CASE OF EMERGENCY?

NAME: _____ TELEPHONE: _____

RELATIONSHIP TO PATIENT: _____

NAME OF SPOUSE/PARENT OR GUARDIAN IF PATIENT IS A MINOR: _____

ADDRESS OF PARENT OR GUARDIAN: _____

CITY, STATE, ZIP: _____

TULI EYE CARE CENTER

2601 W. ALAMEDA AVE. SUITE 206
BURBANK, CA 91505

BILLING INFORMATION

NON-INSURED PATIENTS:

If you are not insured, it is our office policy here at **TULI EYE CARE CENTER** that payment is due at the time services are rendered unless a prior payment arrangement has been made.

I understand that I am financially responsible for payment of all charges incurred for services received from this doctor's office.

_____ _____

Signature of Patient/Guardian if Minor Date

INSURED PATIENTS:

I, the undersigned certify that I (or my dependent) have insurance coverage with:

_____

Name of Insurance Company (ies)

I assign directly to **TULI EYE CARE CENTER** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible of all charges incurred for services received from this doctor's office whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Patient/Guardian if Minor Date

MEDICAL HISTORY QUESTIONNAIRE

Primary Care Physician: _____ Referring /Specialty Dr. _____

Pharmacy: _____ Location(street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Other

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Allergies: Reaction Severity

_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe
_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment

Other _____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK (eye muscle surgery)
□ Punctal Plugs
□ RK
□ Strabismus Surgery
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other _____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens
□ Graves Disease
□ Hyperthyroidism

Other _____

Current Eye Medications: (Please list)

_____
_____
_____

Systemic Illnesses:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke

Other _____

General Surgeries / Operations: (Please list)

_____
_____
_____

Current Other Medications: (Please list)

_____

_____

_____

Infections: (Please mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection

Other_____

Family History:

□ Arthritis
□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ TB

Other_____

Social History: (Please mark all that apply)

Smoking: : □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use □ Yes □ No If yes how much and how often?_____

Drug Use :□ Yes □ No If yes what and how often?_____

Review of systems (please mark all that applies)

Eyes
□ Previous Surgery
□ Contact Lens
□ Pain
□ Double Vision
□ Glaucoma
□ Cataracts
□ Macular Degeneration
□ Dry Eyes
□ Flashes
□ Floaters

Ear nose and Throat
□ Hard of Hearing
□ Ringing in Ears
□ Vertigo

Cardiovascular
□ Chest Pain
□ Dizziness
□ Fainting Spells
□ Shortness of Breath
□ Irregular Heart Beat
□ Difficulty Lying Flat

Constitutional
□ Fatigue / Weakness
□ Fever
□ Weight Gain / Loss

Respiratory
□ Cough
□ Congestion
□ Wheezing
□ Asthma

Gastrointestinal
□ Heartburn
□ Nausea / Vomiting
□ Jaundice / Hepatitus

Genito-Urinary
□ Pain / Difficulty
□ Blood in Urine
□ History of Kidney Stones
□ History of STD's

Psychiatric
□ Anxiety / Depression
□ Mood Swings
□ Difficulty Sleeping

Endocrine
□ Increased Thirst
□ Increased Hunger
□ Increased Urination
□ Increased Sweating
□ Fingernail Changes

Blood / Lymphnodes
□ Easy Bruising
□ Gums Bleed Easy
□ Prolonged Bleeding
□ Heavy Aspirin Use

MusculoSkeletal
□ Stiffness
□ Arthritis
□ Joint Pain / Swelling

Skin
□ Rash / Sores
□ Lesions
□ Hives / Eczema

Neurological
□ Seizures
□ Weakness / Paralysis
□ Numbness
□ Tremors

Immunologic
□ Hives
□ Itching
□ Runny Nose
□ Sinus Pressure

Patient Signature:_____