MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** ___/___/____

Referring Doctor: _____ **Primary Care Physician:** _____

Pharmacy Name and Location (street & city): _____

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

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language: □ English □ French □ Spanish □ Russian □ Italian □ Other_____

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) □ No history of eye problems

□ Amblyopia (Lazy Eye)
□ Astigmatism
□ Cataracts
□ Corneal Disorder
□ Diabetic Retinopathy
□ Dry Eye Syndrome
□ Glaucoma
□ Hyperopia (Farsighted)
□ Iritis/Uveitis
□ Macular Degeneration
□ Myopia (Nearsighted)
□ Retinal Detachment

Other_____

Ocular Surgeries: (Please mark all that apply) □ No prior ocular surgery

R - L	**R - L**	**R - L**
□ □ Blepharoplasty (Lid Surgery)	□ □ Glaucoma Surgery	□ □ Strabismus (eye muscle surgery)
□ □ Cataract Surgery	□ □ Laser Retinal Surgery	□ □ Vitrectomy
□ □ Corneal Transplant	□ □ LASIK	□ □ YAG Laser Capsulotomy

Other_____

Current Eye Medications: (Please list)

_____ _____ _____

_____ _____ _____

Other Medical History: □ No history of illnesses

□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Cancer
□ Congestive Heart Failure
□ COPD
□ Diabetes (circle: Type 1 or Type 2)
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Heart Attack
□ Hepatitis
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ HIV/AIDS
□ Kidney Disease
□ Liver Disease
□ Lupus
□ Migraine
□ Multiple Sclerosis
□ Polymyalgia Rheumatica
□ Psychiatric Disorder
□ Rheumatoid Arthritis
□ Stroke
□ Thyroid Disease

Other_____

General Surgeries/Procedures: (Please list)

_____ _____ _____

_____ _____ _____

All Other Medications including *blood thinners*: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please continue on the back side of this page →

Family History: (Please indicate relationship) □ No history of illnesses □ History unknown

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

Social History: (Please mark all that apply)

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

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

Drug Use: □ No □ Yes If yes, which and how long? _____

Review of Systems: (Please mark all that apply)

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 / Hepatitis

Genitourinary
- □ 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/Lymph Nodes
- □ 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: _____ **Date:** _____

Reviewed by: _____ Date**:** _____

Signature on File, Assignment of Benefits, Financial Agreement

_____ _____

Beneficiary Name (*print)* Insurance ID Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to __Barry S. Seibel, MD, Inc., for services furnished me by __Barry S. Seibel, MD, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Barry S. Seibel, MD, Inc., accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Barry S. Seibel, MD, Inc., if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Barry S. Seibel, MD, Inc. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Barry S. Seibel, MD, Inc. for reimbursement for services rendered, and (2) any health care provider for continued patient care. Barry S. Seibel, MD, Inc. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Barry S. Seibel, MD, Inc. maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Barry S. Seibel, MD, Inc. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Barry S. Seibel MD, Inc. if I belong to a plan that does not appear on the above-mentioned list.

5. **NON-COVERED SERVICES:** I understand that Barry S. Seibel, MD, Inc. contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are “covered” by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient’s contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Barry S. Seibel, MD, Inc. to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Barry S. Seibel, MD, Inc. I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Barry S. Seibel, MD, Inc. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney’s fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Barry S. Seibel, MD, Inc. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Barry S. Seibel, MD, Inc. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

_____ _____

Beneficiary Signature or Authorized Party Date

SEIBEL VISION SURGERY
BARRY S. SEIBEL, M.D.

Notice of Privacy Practices
To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Private Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law, to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances.
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary, to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcements officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

Your rights regarding your health
1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Barry S. Seibel, M.D. Inc., (310) 444-1134.

(PLEASE CONTINUE ON THE BACK OF THIS PAGE)

11620 Wilshire Blvd., Suite 711, Los Angeles, CA 90025

(310)444-1134 Phone (310)444-1130 Fax

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Barry S. Seibel, M.D., Inc. - 11620 Wilshire Blvd., Suite 711, Los Angeles, CA. 90025. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of Health and Human Services. To file a complaint with our practice, contact Barry S. Seibel, M.D. Inc., (310) 444-1134. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses, and disclosures that are not identified by this notice, or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Barry S. Seibel, M.D. Inc., (310) 444-1134.

I hereby acknowledge that I have been presented with a copy of Barry S. Seibel, M.D. Inc., Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient _____

Seibel Vision Surgery

Barry S. Seibel, M.D.

DEMOGRAPHICS QUESTIONNAIRE

NAME: _____ **DATE:** _____
(LAST) (FIRST) (MI)

ADDRESS: _____
ADDRESS CITY STATE ZIP CODE

E-MAIL ADDRESS: _____ **FAX NUMBER:** _____

HOME #: _____ **WORK #:** _____ **EXT.:** _____ **MOBILE#:** _____

PREFERED METHOD OF CONTACT: ☐ **HOME #** ☐ **MOBILE #** ☐ **EMAIL**

BIRTH DATE: _____ **AGE:** _____ **GENDER:** ☐ **MALE** ☐ **FEMALE**

OCCUPATION (CURRENT OR FORMER): _____

RETIRED: ☐ **YES** ☐ **NO** **EMPLOYER:** _____

ACTIVITIES/HOBBIES: _____

_____
NAME OF EMERGENCY CONTACT RELATIONSHIP TO YOU PHONE #

MAY WE SPEAK WITH YOUR EMERGENCY CONTACT REGARDING YOUR CARE: ☐ **YES** ☐ **NO**

PRIMARY INSURANCE: _____ **ID#:** _____

SUBCRIBER: _____ **DOB:** _____

SECONDARY INSURANCE: _____ **ID#:** _____

SUBSCRIBER: _____ **DOB:** _____

WHAT ARE YOUR CONCERNS OR REASON FOR THE REFERRAL? _____

_____

HOW WERE YOU REFERRED TO OUR OFFICE? _____

YOUR PRIMARY PHYSICIAN IS: _____ **Phone#:** _____

YOUR GENERAL EYE DOCTOR IS: _____ **Phone#:** _____

Barry S. Seibel, M.D., Inc.
www.vision-surgery.com
11620 Wilshire Blvd., Suite 711, Los Angeles, CA 90025
Phone: (310)444-1134 **Fax: (310)444-1130**