

Southland Eye

Lee H. Novick, M.D. Ryan C. Larscheid, M.D. Omid Khodai, O.D.

Patient Information

Date: _____

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Telephone: () _____ () _____ () _____
Home (please circle the number you prefer we use) Cell Work

Patient e-mail address: _____ **May we communicate via e-mail?**

In effort of being able to continue to remind our patients of their appointment times we will be converting to e-mail notification.

Date of Birth: _____ Age: _____ Sex: M _____ F _____ Marital Status: _____

Social Security Number: _____

Primary Care Physician: _____ Ph# _____
Address: _____ City: _____ Zip: _____

Referring Physician: _____ Ph# _____
Address: _____ City: _____ Zip: _____

Emergency Contact: _____ PH# () _____ Relationship: _____

Pharmacy Name and Location: _____ Ph# _____

Employer Name: _____ Address: _____
Ph# _____

Insurance Information

Primary Insurance Name: _____ ID# _____ PPO _____ HMO _____
Insured _____ Group# _____ PH# _____ circle one

Secondary Insurance Name: _____ ID# _____ PPO _____ HMO _____
Insured _____ Group# _____ PH# _____

Responsible Party: (who pays your bills) ___ Self ___ Other _____ Relationship _____

Treatment Authorization

I hereby authorize providers of Southland Eye to perform an Ophthalmological consultation and examination and to initiate diagnosis and therapeutic treatments that may be considered advisable or necessary upon examination.

Patient Signature: _____ Date: _____

Parent Signature: (minor patient) _____

How did you find us? Physician referral _____ Phone Book _____ Insurance Book _____ Internet _____
Family friend _____ Other _____

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Medical History

Name: _____

Date of Birth _____

Reason for Visit: _____

Do you smoke cigarettes? _____ take blood thinners? _____ take aspirin daily? _____ exercise? _____

Are you pregnant? _____ allergic to any local anesthetic? _____

Family History

Questions refer to your: grandparents (**gm / gf**) Aunts / Uncle (**a / u**) Brothers / Sisters (**b / s**) Parents (**m / f**)

Cancer _____

Heart Disease _____

Glaucoma _____

Macular Degeneration _____

Retina disorders _____

Cataracts _____

Other Eye conditions _____

List other eye conditions _____

Migraines _____

Allergies / Asthma _____

Diabetes _____ Type _____

High Blood Pressure _____

HIV _____

Kidney Disease _____

Liver disease/ Hepatitis _____

Autoimmune Disease _____

Patient Medical History

Do you have or have you had any of the following? (*if yes, please check*)

Cancer _____

Heart Disease _____

Glaucoma _____

Macular Degeneration _____

Retina disorders _____

Cataracts _____

Other Eye conditions _____

Eye injury / trauma _____

Eye surgery _____ type _____ date _____

List other eye conditions: _____

Migraines _____

Allergies / Asthma _____

Diabetes _____ Type _____

High Blood Pressure _____

HIV _____

Kidney Disease _____

Liver disease/ Hepatitis _____

Cold sores / Herpes _____

Autoimmune Disease _____

Please list any Medications, herbal supplements and / or vitamins you are currently taking:

If this is not enough space please list remainder of medications on the back of this form. See reverse _____

Medication allergies: _____

Major surgeries / hospitalization:

_____ date: _____

_____ date: _____

_____ date: _____

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Signature Page

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, or to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

Signature: _____ Date: _____

Assignment of Benefits

I authorize Southland Eye to bill my insurance on my behalf. I assign payment of medical benefits for services rendered to Southland Eye. I understand that it may be necessary to supply my insurance company with medical and or personal information about myself in order to process insurance claims.

Signature: _____ Date: _____

Medicare Patients Only Please sign below so that we may bill Medicare on your behalf.

I authorize Southland eye, a holder of my medical information to release information about me to the Social Security Administration and Center for Medicare or its intermediaries or carrier, any information needed for this or related Medicare claims. I permit a copy of this authorization to be used In place of the original, and request payment of medical insurance benefits to this provider of service. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Signature: _____ Date: _____

*** Pleases sign only if you are a Medicare patient***

Private Practices (HIPAA)

Please sign below to acknowledge receipt of the Notice of Privacy Practices of the office of Southland Eye. Our Notice of Privacy Practice provides information about how to use and disclose your protected health information. We encourage you read it in full. Our Notice of Privacy Practice is subject to change. You may contact this office for a copy of this notice at any time.

I have been provided for my review, a copy of Privacy Practices for Southland Eye and have reviewed this information to my satisfaction. I am aware that a copy of this notice is available to me upon request.

Contact information: By signing below, I authorize Southland Eye to leave message in reference to any items that assist the practice in carrying out healthcare operations. Please indicate below any contacts in which you **do not** wish to be contacted: _____ Home _____ Cell _____ Work _____ e-mail _____

Signature: _____ Date: _____

Please list any persons to whom your protected health information can be disclosed or discussed:

Name: _____ Relationship: _____

Name: _____ Relationship: _____