

PATIENT INFORMATION
PACIFIC EYE SPECIALISTS
BERND KUTZSCHER, MD MICHAEL HEE, MD CAROLINE FISHER, MD

NAME: _____ DATE OF BIRTH: _____

(Mr. Mrs. Miss Ms)

NAME OF SPOUSE (OR RESPONSIBLE PARTY IF MINOR): _____

HOME ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: _____
(Area Code)

BUSINESS ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP)

BUSINESS PHONE: _____ OCCUPATION: _____
(Area Code)

E-MAIL ADDRESS _____ FAX # _____

EMERGENCY CONTACT: Name _____ Ph.# _____

SOC. SEC. # _____ - _____ - _____

REFERRED TO THIS OFFICE BY: _____

FAMILY DOCTOR NAME: _____

FAMILY DOCTOR ADDRESS: _____

MEDICAL INSURANCE POLICY NAME AND # and SUBSCRIBER NAME (or present your card):

SECONDARY INSURANCE POLICY NAME AND # and SUBSCRIBER NAME (or present your card):

VISION INSURANCE SUBSCRIBER NAME AND POLICY # (or present your card):

IF ANOTHER PERSON IS SUBSCRIBER FOR ANY POLICY ABOVE: DATE OF BIRTH _____

NAME _____ SOC. SEC. # _____ - _____ - _____

By signing below, I authorize my insurance benefits to be paid directly to the doctor and agree that I will be responsible for non-covered services. I authorize my physician or his agents to release any information to my insurance to process claims for my care.

⇒SIGNATURE: _____ DATE: _____

By signing below, I acknowledge that I am aware that this office (Pacific Eye Specialists) has a privacy policy that is designed to protect the privacy of my medical information and that is based on the standards of the "Health Insurance Portability and Accountability Act" (HIPAA). I understand that health care providers are allowed to use my confidential information for purposes of treatment, payment or healthcare operations, and I authorize this use by Pacific Eye Specialists. I understand that a written summary of the privacy policy is available and that I may review it.

⇒SIGNATURE: _____ DATE: _____

**PATIENT INFORMATION
PACIFIC EYE SPECIALISTS**

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• **GENERAL HEALTH**

Please mark any areas of concern about your health:

<input type="checkbox"/> Wt. Loss/Fevers	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Heart Attack/angina	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Sinus disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Neurological problem
<input type="checkbox"/> Bleeding problem	<input type="checkbox"/> HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> TB
<input type="checkbox"/> Check if pregnant	<input type="checkbox"/> Prior severe injury	<input type="checkbox"/> Anesthesia problems	<input type="checkbox"/> Other

• **EYE HEALTH**

Have you ever had (or been told you have):

<input type="checkbox"/> Cataract	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Retinal detachment
<input type="checkbox"/> Diabetic retinopathy	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Eye trauma	<input type="checkbox"/> Other eye disease

• **RISK FACTORS**

Do you smoke? Yes Do you drink alcohol daily? Yes Do you work around machinery? Yes

• **FAMILY EYE HISTORY**

Is there any family history of:

<input type="checkbox"/> Cataract	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Retinal detachment
<input type="checkbox"/> Diabetic retinopathy	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Eye trauma	<input type="checkbox"/> Other eye disease

Detail:

- **MEDICATIONS** - Please list medications you are currently using:

- **ALLERGY TO MEDICATIONS** - Please list allergies to medications:

- **I am interested in:** new glasses new contact lenses cataract surgery information

Crystalens information lens implant for astigmatism laser vision correction

macular degeneration information glaucoma information diabetes information

dry eye information eye color changing contact lenses

Botox, Juvederm and other cosmetic information

Latisse- eyelash growth

- Please note that you may be charged separately for a glasses or contact lens prescription if your insurance does not cover that service.
- If you currently wear contact lenses, please wear them to your appointment. For new patients, please bring your contact lens prescription information with you.