

**PATIENT INFORMATION  
PACIFIC EYE SPECIALISTS**

**BERND KUTZSCHER, MD MICHAEL HEE, MD CAROLINE MENDOZA-FISHER, MD**

NAME: Mr. Mrs. Miss Ms) \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

SOC. SEC. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

NAME OF SPOUSE (OR RESPONSIBLE PARTY IF MINOR): \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
(Area Code) (Area Code)

BUSINESS ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

BUSINESS PHONE: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
(Area Code)

E-MAIL ADDRESS \_\_\_\_\_ @ \_\_\_\_\_

EMERGENCY CONTACT: Name \_\_\_\_\_ Ph.# \_\_\_\_\_

REFERRED TO THIS OFFICE BY: \_\_\_\_\_

FAMILY DOCTOR NAME/ADDRESS: \_\_\_\_\_

MEDICAL INSURANCE POLICY NAME ( present your card): \_\_\_\_\_ SUBSCRIBER NAME

SECONDARY INSURANCE POLICY NAME ( present your card): \_\_\_\_\_ SUBSCRIBER NAME

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: \_\_\_\_\_

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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, eyelash growth and other cosmetic information

(Please note that you may be charged separately for a glasses or contact lens prescription if your insurance does not cover that service)