Robert C. Erickson, M.D Timothy P. Page, M.D. Maria Jancevski, M.D.

OAKLAND
OPHTHALMIC
SURGERY, P.C.

Patient Information:

Patient Name (Last, First, MI):_____

Birthdate:_____ Social Security #:_____ Gender: __M __F

Home Address:_____City_____State_____Zip_____

Home #:_____ Work #:_____

Cell #:_____ ER contact Name & phone #:_____

E-mail:_____

Marital Status: Single Married Widow Divorced

Primary Care Physician _____ Office Phone: _____

Referring Physician_____ Office Phone: _____

Meaningful use information:
Primary Language_____ Race_____ Ethnicity_____

If patient is a minor:
Guardian Name:_____ Birthdate_____ Social Security # (last 4) _____

Signature_____**Date**_____

E-prescribing allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacy electronically, through a secure internet connection, instead of using handwritten or faxed notes or calling in prescriptions. Please provide your pharmacy information below.

PHARMACY Name: _____

CITY Pharmacy is in: _____

PHARMACY Phone Number:_____

PHARMACY Crossroads: _____

Vision Insurance VS Medical Insurance

What is the difference? We hope we can clarify this question for you.

Your vision insurance is a "rider" that either you or your employer purchases to receive coverage for a routine eye exam and glasses or contact lenses. Medical insurance is intended to cover services when a medical condition exists.

How do I know if my visit is medical or vision?

Your vision insurance would apply for a routine eye examination if you:

- Have no known problems with your eyes except for needing new glasses.

AND/OR

- Were not referred by another physician.

AND/OR

- Your previous eye examinations by Dr. Erickson, Dr. Page, or Dr. Jancevski did not show any medical conditions.

If the above does not apply then we need to address the medical condition and use your medical insurance.

Examples of medical conditions: Cataracts, glaucoma or suspicion of glaucoma, macular degeneration, implants, red eyes, tearing, irritation, pain, etc.

Health and Social History

Patient Name_____ Birth date_____

Do you have or have you had any of the following? (please check)

- ☐ Acid Reflux
- ☐ Allergies
- ☐ Alzheimer's/Dementia
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto Immune Disease
- ☐ Breathing Problems
- ☐ Bleeding Tendencies
- ☐ Cancer _____
- ☐ Carotid Artery Disease
- ☐ Colitis
- ☐ Crohn's
- ☐ Depression
- ☐ Diabetes- Type 1__Type 2__
- ☐ Emphysema
- ☐ Enlarged Prostate
- ☐ Heart Attack
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Herpes S Virus
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ MRSA
- ☐ Multiple Sclerosis (MS)
- ☐ Myasthenia Gravis
- ☐ Migraines
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Sarcoid
- ☐ Seizures
- ☐ Shingles
- ☐ Sinus
- ☐ Sjogren's
- ☐ Stroke
- ☐ Thyroid Hyper/Hypo
- ☐ Tuberculosis
- ☐ Wegner's
- ☐ Other_____

Have you had any past eye Surgery/ Trauma: Please List:
Right Eye: _____ Left Eye: _____

Surgeries/ hospitalizations within the last 5 years: _____

Social History:
Tobacco use: Current Smoker_____ Former Smoker _____ Never Smoked_____
Alcohol use: Current Drinker_____ Former Drinker _____Never Drinker_____
Average drinks number of drinks: _____ per _____ (day, week or month)

Do you currently drive a Car? Yes_____ No_____
Do you live alone? Yes_____ No_____

Family History (Immediate Family)

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Cataract			
Diabetes			
Glaucoma			
Macular Degeneration			

Primary Care Physician_____ **Phone**_____
Endocrinologist_____ **Phone**_____
Rheumatologist_____ **Phone**_____

Today's Date_____

MEDICATIONS/ ALLERGIES

Patient Name_____ Birth date_____

Please list all current Medications, Vitamins or Supplements. If you have a list we can make a copy. If you are unsure of the name of Medication please list what type of Medication you are taking and what condition you are taking it for.

MEDICATION	DOSE	TIMES PER DAY	WHAT IS THE MEDICATION USED FOR

Please List All Allergies ☐ None

ALLERGIES	REACTION	ALLERGIES	REACTION

Today' s Date_____

sg/kg2020

AUTHORIZATION FOR DISCLOSURE OF TREATMENT

This signature page is designed for you to establish limitations on what information we can share with people other than your insurance company or Drs. who coordinate your care. If you have certain family members or caregivers that normally assist you in either your health care decisions or financial decisions, you may wish to include them on this form. If you do not authorize anyone on this form, please be aware that we will not be allowed to answer any questions regarding your care, including billing, to anyone but *you* (including your spouse, siblings, adult children, and caregivers).

I authorize the person(s) named below to discuss my care in my absence and obtain my medical records if necessary (this does not include doctors who are involved in my care). I understand this authorization is in effect unless I revoke the authorization in writing.

Authorized Individuals:

Name	Relationship	Phone

Specific information to be disclosed (check all that apply):

- ☐ Office Notes
- ☐ Diagnostic/Imaging
- ☐ Financial/Billing
- ☐ Other _____

_____ _____

PATIENT SIGNATURE DATE

Form must be signed and dated each year.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

At the Oakland Ophthalmic Surgery, we believe that your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are also required by law to respect your confidentiality.

This Notice describes the privacy practices of Oakland Ophthalmic Surgery. This Notice applies to all of the health records that identify you and the care you receive at Oakland Ophthalmic Surgery. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of the Notice that is currently in effect.

Please review it carefully.

- Oakland Ophthalmic Surgery may disclose your health and/or medical information to treating health care professionals including but not limited to: physicians, nurses, lab technicians, and pharmacists.
- Oakland Ophthalmic Surgery will disclose your health and/or medical information when we are required to do so by Federal, State, or Local Law.
- Oakland Ophthalmic Surgery may disclose your health and/or medical information to third party payers, Insurance companies, and/or billing companies in order to receive payment for the services you received.
- Oakland Ophthalmic Surgery may confirm appointments, leave a medically related message, or leave a message related to your financial account on your home or cell phone, answering machine and/or voicemail, or directly with a person at your home.
- You have the right to inspect and obtain a copy of your health and/or medical information. This request must be in writing, there is a reasonable fee for copying the records.

I understand that the statements above are only a summary of Oakland Ophthalmic Surgery's Privacy Practices. I have been offered to retain my own complete copy of the Privacy Practices as well as the opportunity to review an office copy of the complete version.

Signature of patient _____ Date _____

Guardian must sign for minor

Witness _____ Date _____