CAREY VISION MEDICAL GROUP, INC.

MEDICAL HISTORY QUESTIONAIRE

NAME .... PRIMARY CARE PHYSICIAN ....

DATE ....../....../...... REFERRED BY: ....

DATE OF BIRTH ....../....../...... AGE .... YOUR OCCUPATION: ....

MARITAL STATUS:	☐ MARRIED	☐ SINGLE	☐ WIDOWED
ALCOHOL USE:	☐ NEVER	☐ HEAVY	☐ OCCASIONAL
TOBACCO USE:	☐ NEVER	☐ HEAVY	☐ OCCASIONAL
DRUG USE:	☐ NEVER	☐ HEAVY	☐ OCCASIONAL

DO YOU USE GLASSES FOR: ☐ DISTANCE ☐ NEAR ☐ BOTH

DO YOU USE CONTACT LENSES: ☐ NEVER ☐ REGULARLY ☐ OCCASIONALLY

	Yes	No		Yes	No
BLURRED DISTANCE VISION WITH GLASSES	☐	☐	LOSS OF SIDE VISION	☐	☐
BLURRED NEAR VISION WITH GLASSES	☐	☐	GLARE/LIGHT SENSITIVITY	☐	☐
HEADACHE OR FATIGUE AFTER WORK	☐	☐	EYE PAIN	☐	☐
DOUBLE VISION	☐	☐	CHRONIC EYE INFECTION	☐	☐

LIST CURRENT MEDICATIONS

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

	Yes	No		Yes	No
1. GLAUCOMA	☐	☐	8. CROSSED EYE	☐	☐
2. DIABETIC EYE DISEASE	☐	☐	9. RETINAL DETACHMENT	☐	☐
3. MACULAR DEGENERATION	☐	☐	10. BLEEDING IN THE EYE	☐	☐
4. CATARACT	☐	☐	11. INJURY TO THE EYE	☐	☐
5. DRY EYE	☐	☐	12. LASER TREATMENT	☐	☐
7. THYROID EYE DISEASE	☐	☐	13. BLOCKED TEAR DUCT	☐	☐
9. LAZY EYE	☐	☐	14. SURGERY/LASER (LIST)		

DATE	OPERATION

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

	Yes	No		Yes	No
15. DIABETES	☐	☐	22. ARTHRITIS	☐	☐
16. THYROID DISEASE	☐	☐	23. PSYCHIATRIC DISORDER	☐	☐
17. HEART DISEASE	☐	☐	24. IMMUNE PROBLEMS	☐	☐
18. ASTHMA	☐	☐	25. TUBERCULOSIS	☐	☐
19. CANCER	☐	☐	26. KIDNEY DISEASE	☐	☐
20. HIGH BLOOD PRESSURE	☐	☐	27. PAST SURGERIES(LIST)		
21. STROKE	☐	☐	28. HOSPITALIZATIONS (LIST)		

DATE	OPERATION

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

	Yes	No		Yes	No
29. CHEST PAIN	☐	☐	36. LOSS OF BALANCE	☐	☐
30. SHORTNESS OF BREATH	☐	☐	37. UNUSUAL WEIGHT LOSS	☐	☐
31. REGULAR COUGHING	☐	☐	38. FREQUENT HEADACHES	☐	☐
32. COUGHING UP BLOOD	☐	☐	39. BLEEDING PROBLEM	☐	☐
33. NIGHT SWEATS	☐	☐	40. SWOLLEN GLANDS	☐	☐
34. BLOODY URINE OR STOOL	☐	☐	41. DIZZINESS	☐	☐
35. RINGING IN EARS	☐	☐	42. PAIN	☐	☐

PLEASE LIST ALL DRUG ALLERGIES

NONE ☐

DO YOU KNOW OF ANY DISEASES THAT RUN IN YOUR FAMILY?

	Yes	No		Yes	No
43. GLAUCOMA	☐	☐	48. LAZY EYE	☐	☐
44. DIABETES	☐	☐	49. STROKE/HEART ATTACK	☐	☐
45. CATARACT	☐	☐	50. RETINAL DETACHMENT	☐	☐
46. HEART DISEASE	☐	☐	51. MACULAR DEGENERATION	☐	☐
47. CANCER	☐	☐	52. RETINITIS PIGMENTOSA	☐	☐

USE REVERSE SIDE TO EXPLAIN ANY "YES" ANSWERS.

REORDER FROM MIKE ANDERSON (408) 938 - 4204 EYEMHQ.FOB

HISTORY REVIEWED

INITIALS ____ /____ /____ INITIALS ____ /____ /____ INITIALS ____ /____ /____ INITIALS ____ /____ /____

INITIALS ____ /____ /____ INITIALS ____ /____ /____ INITIALS ____ /____ /____ INITIALS ____ /____ /____

PLEASE EXPLAIN ANY "YES" ANSWERS FROM QUESTIONS ON THE REVERSE SIDE.

BE SURE TO NUMBER EACH EXPLANATION WITH AN ITEM NUMBER.

Bart A. Carey, MD
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Carey Vision Medical Group, Inc.

Comprehensive Ophthalmology • Specializing in Laser Vision Correction

PATIENT INFORMATION

CIRCLE ONE:	MR. MRS. MS.
FIRST NAME:	
MIDDLE INITIAL:	
LAST NAME:	
DRIVER'S LICENSE NO.:	
SOCIAL SECURITY NO.:	
HOME PHONE:	
WORK PHONE:	EXT.:
E-MAIL:	
STREET ADDRESS:	
CITY, STATE, ZIP:	
DATE OF BIRTH:	AGE: SEX:
EMPLOYER:	
OCCUPATION:	
In case of emergency contact:	PHONE:
How did you hear about us?	☐ Insurance (Name) ☐ Telephone book ☐ Doctor (Name) ☐ Friend/Relative (Name) Please specify:
PRIMARY CARE PHYSICIAN:	
PRIMARY INSURANCE COMPANY NAME:	
POLICY NUMBER:	GROUP NUMBER:
Who is the Subscriber?	
Coverage date from:	To:
SECONDARY INSURANCE COMPANY NAME:	
POLICY NUMBER:	GROUP NUMBER:
Who is the Subscriber?	
Coverage date from:	To:

Continued on other side

PATIENT INFORMATION

If patient is a minor (Under 18), indicate name of both parents or legal guardian in space below:

CIRCLE ONE:	MR. MRS. MS.
FIRST NAME:	
MIDDLE INITIAL:	
LAST NAME:	
SOCIAL SECURITY NO.:	
HOME PHONE:	
WORK PHONE:	EXT.:
STREET ADDRESS:	
CITY, STATE, ZIP:	
DATE OF BIRTH:	SEX:

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Carey Vision Medical Group to furnish information to insurance carries concerning my illness and treatments and I hereby, assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

SIGNATURE: ____________________ DATE: __________

MEDICARE AUTHORIZATION

NAME OF BENEFICIARY: ____________________ HIC NUMBER: __________

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Carey Vision Medical Group for any services furnished me by that physicians/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim if item 9 of the HCFA 1500 claim form is completed, my signature authorizers releasing of the information to the insurer or agency shown in Medicare assigned cases, the Physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE: ____________________ DATE: __________

CREDIT POLICY

Please read and sign our Credit Policy.

- All bill will be due and payable at the time of service (unless other arrangement have been made).
- All Co Pays are due at the time of service.
- We accept Visa/Mastercard, cash and personal checks.
- In order to bill your insurance properly, we will need copies with name, address and ID numbers and your insurance card.
- As a courtesy to our patients we do not charge interest on accounts past due. If necessary, delinquent accounts will be sent to a collection agency.

I have read the above agreement and agree to the terms hereof.

SIGNATURE: ____________________ DATE: __________

CAREY VISION MEDICAL GROUP, INC.

BART A. CAREY M.D

GEORGE HEWES M.D.

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SUITE 361
MOUNTAIN VIEW, CA 94040
650-969-6300

2110 FOREST AVE.
SUITE B
SAN JOSE, CA 95128
408-295-3433

Dear Patient:

The Federal government now requires all physicians to have policies in place to protect the privacy of each patient's health care information. We are required to inform you of this law and of our steps to insure that your healthcare information is kept private. We are also required to ask you to sign this form, indicating that you understand our policies to protect your privacy. You will be asked to sign this form on your initial visit to our office, or on your first visit back after April 14, 2003.

By signing below, you acknowledge that you are aware that this office has a privacy policy that is designed to protect the privacy of your medical information, and this policy is based on the standards of the "Health Insurance Portability and Accountability Act (HIPPA)."

Healthcare providers are allowed to use confidential information for purposes of treatment, payment, or ongoing healthcare. By signing below you authorize this use by Carey Vision Medical Group (CVMG) physicians, nurses, technicians, opticians, business office/billing personnel, receptionists, and medical record personnel.

By signing below you acknowledge that you understand that a written summary of the privacy policy is available for your review, and you may request a copy of the privacy policy upon request. Note that CVMG may not condition treatment on signing this authorization, and you have the right to refuse to sign this authorization. If you do not sign this authorization, CVMG reserves the right to bill for services performed on your behalf, which may include forwarding confidential information to your insurance company if you request that your insurance company is billed.

____ ______________________
Patient **Date:**