



Carey Vision Medical Group, Inc.
Comprehensive Ophthalmology • Cataract and Refractive Surgery

Instructions

Filling out Forms prior to your first visit to our office:

- Please print all forms;
- Fill out applicable information;
- Fax to 408-293-4872 or
- Email forms to; info@careyvision.com

Thank you in advance, we look forward to your first visit with our office.

Carey Vision Medical Group
Phone (408) 295-3433
Fax (408) 293-4872
Email to info@careyvision.com



PATIENT INFORMATION

NAME									
E-MAIL									
SS#									
ADDRESS									
CITY						STATE		ZIP	
DATE OF BIRTH / /				AGE		SEX		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME PHONE ()			WORK PHONE ()			CELL PHONE ()			
REFERRING DOCTOR						PHONE		()	
EMERGENCY NOTIFICATION						PHONE		()	
PATIENT'S EMPLOYER									

MEDICAL INSURANCE #1 INFORMATION

MEDICAL INSURANCE COMPANY									
ADDRESS									
CITY						STATE		ZIP	
SUBSCRIBER LAST NAME				FIRST NAME				M.I.	
SUBSCRIBER SS#		SUBSCRIBER'S DATE OF BIRTH / /				SUBSCRIBER SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
POLICY ID #			GROUP NO.			RELATIONSHIP TO SUBSCRIBER			

MEDICAL INSURANCE #2 INFORMATION

MEDICAL INSURANCE COMPANY									
ADDRESS									
CITY						STATE		ZIP	
SUBSCRIBER LAST NAME				FIRST NAME				M.I.	
SUBSCRIBER SS#		SUBSCRIBER'S DATE OF BIRTH / /				SUBSCRIBER SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
POLICY ID #			GROUP NO.			RELATIONSHIP TO SUBSCRIBER			

VISION INSURANCE INFORMATION

MEDICAL INSURANCE COMPANY									
ADDRESS									
CITY						STATE		ZIP	
SUBSCRIBER LAST NAME				FIRST NAME				M.I.	
SUBSCRIBER SS#		SUBSCRIBER'S DATE OF BIRTH / /				SUBSCRIBER SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
POLICY ID #			GROUP NO.			RELATIONSHIP TO SUBSCRIBER			

SIGNATURE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical, Medical and/or Vision Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services					Signature					Date				
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Physician to release any information acquired in the course of my treatment necessary to process insurance claims.					Signature					Date				
I understand that by not supplying my complete insurance information or by not providing insurance information I will be responsible for all account balances, and that failure to obtain prior authorization and/or denied prior authorization will result in my being fully responsible for all account balances.					Signature					Date				



MEDICAL HISTORY QUESTIONNAIRE

NAME _____ PRIMARY CARE PHYSICIAN _____
 DATE _____ REFERRED BY _____
 DATE OF BIRTH _____ 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 UUSE CONTACT LENSES NEVER REGULARLY OCCASIONALLY

LIST CURRENT MEDICATIONS

BLURRED DISTANCE VISION WITH GLASSES	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	LOSS OF SIDE VIEW	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BLURRED NEAR VISION WITH GLASSES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GLARE/LIGHT SENSITIVITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEADACHE OR FATIGUE AFTER WORK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOUBLE VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHRONIC EYE INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

	YES	NO		YES	NO	DATE/EXPLAIN
GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	CROSSED EYE	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETIC EYE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	RETINAL DETACHMENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
MACULAR DEGENERATION	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING IN THE EYE	<input type="checkbox"/>	<input type="checkbox"/>	_____
CATARACT	<input type="checkbox"/>	<input type="checkbox"/>	INJURY TO THE EYE	<input type="checkbox"/>	<input type="checkbox"/>	_____
DRY EYE	<input type="checkbox"/>	<input type="checkbox"/>	LASER TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
THYROID EYE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BLOCKED TEAR DUCT	<input type="checkbox"/>	<input type="checkbox"/>	_____
LAZY EYE	<input type="checkbox"/>	<input type="checkbox"/>	SURGERY/LASER (LIST)	<input type="checkbox"/>	<input type="checkbox"/>	_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

	YES	NO		YES	NO	DATE/EXPLAIN
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	PAST SURGERIES (LIST)	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	HOSPITALIZATIONS (LIST)	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

	YES	NO		YES	NO
CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	LOSS OF BALANCE	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	UNUSUAL WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>
REGULAR COUGHING	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>
COUGHING UP BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>
NIGHT SWEATS	<input type="checkbox"/>	<input type="checkbox"/>	SWOLLEN GLANDS	<input type="checkbox"/>	<input type="checkbox"/>
BLOODY URINE OR STOOL	<input type="checkbox"/>	<input type="checkbox"/>	DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>
RINGING IN EARS	<input type="checkbox"/>	<input type="checkbox"/>	PAIN	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE LIST ALL DRUG ALLERGIES

NONE

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

	YES	NO		YES	NO
GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	LAZY EYE	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	STROKE/HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>
CATARACT	<input type="checkbox"/>	<input type="checkbox"/>	RETINAL DETACHMENT	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	MACULAR DEGENERATION	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	RETINITIS PIGMENTOSA	<input type="checkbox"/>	<input type="checkbox"/>

**USE 2ND PAGE
TO EXPLAIN ANY
"YES" ANSWERS**



Carey Vision Medical Group, Inc.
Comprehensive Ophthalmology - Cataract and Refractive Surgery

2110 Forest Ave Suite B
San Jose, CA 95128
Phone (408)295-3433
Fax (408)293-4872

Patient Name _____

Patient Number _____

Email Address _____

****Notice to our Patients,**

We are collecting email addresses to facilitate efficient communications between our patients and Physicians and/or other CVMG staff.

If you choose to provide us with your E-Mail Address, we may use e-mail communications for future appointment inquiries, appointment reminders, and/or billing and statement inquiry communications.

Providing us with your e-mail address may also be used to send you CVMG News Letters, or, interesting information related to free upcoming seminars and other information about our practice or your eye care health.

*Signature below indicates I choose to provide CVMG with my e-mail which may be used for e-mail communications.

Patient Authorization Signature: _____ Date: _____



Carey Vision Medical Group, Inc.
Comprehensive Ophthalmology - Cataract and Refractive Surgery

2110 Forest Ave Suite B
San Jose, CA 95128
Phone (408)295-3433
Fax (408)293-4872

Patient _____

DOB _____

The Federal government now requires all physicians to protect the privacy of each patient's health care information. We are required to inform you of this law and our steps to insure that your health care 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.

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 the purposes of treatment, payment, or on going 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 personal.

By signing below you acknowledge that you understand that a written summary of the privacy 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 or Guardian

Date