ATLANTIS
EYECARE

Welcome to Atlantis Eyecare! Thank you for choosing us for your complete eye care needs. The following packet has been provided to help prepare you for your upcoming visit. In order to receive the most effective care, we ask that you bring the following with you to your initial appointment.

- Attached completed forms
- Medical and Vision insurance cards
- Drivers license or other form of photo identification
- Complete list of current medications; dosage and frequency
- Current prescription of eye glasses or contacts (contact box)
- (If) you are being referred to us by another ophthalmologist please bring medical records
- (If) you require any type of special assistance please contact our office before the visit

New patient appointments take 1 to 2 hours. As part of a thorough new patient exam your eyes may be dilated. Dilation typically remains for 3-6 hours after your examination. During this time your near vision will be compromised and you will experience light sensitivity. Therefore, before leaving our facilities we will provide you with disposable sunglasses. Most people are able to drive following dilation, but you may want to bring a driver if you have experienced problems driving in the past, or if your eyes have never been dilated.

If your insurance requires that you have a referral from your Primary Care Physician, please call their office to obtain your referral prior to your appointment. Failure to obtain a referral could delay your appointment. All co-payments and any additional services not covered will be collected at the time of your appointment.

Please call your insurance should you have any questions regarding coverage. You will be held responsible for any fees not covered by insurance.

Please note: For all patients under the age of 18, a parent or legal guardian must accompany him or her.

We encourage you to visit our website at www.atlantiseyecare.com where you will find educational videos, frequently asked questions, and more.

To make your experience with Atlantis Eyecare as efficient as possible, we ask that you complete the attached forms prior to your arrival. Should you have any questions for us prior to your visit, please do not hesitate to call. We look forward to meeting you soon.

Sincerely,

Atlantis Eyecare Physicians and Staff

POS® Reorder # 1418052

ATLANTIS
EYECARE

ANAHEIM

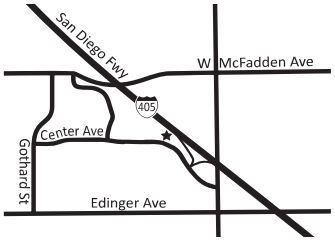
947 S. Anaheim Blvd., Suite 120, Anaheim, CA 92805
Phone: (714) 991-4100
*Diabetic Retinal Screening walk-in hours,
Monday-Friday 8:30-11:30 am & 1:30-4:20 pm

SANTA ANA

1595 E. 17 St., Santa Ana, CA 92705
Phone: (714) 984-0788
*Diabetic Retinal Screening by Appointment Only

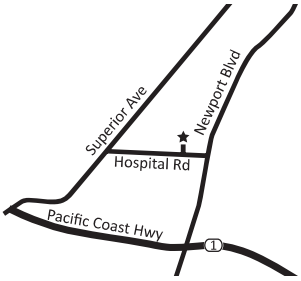
HUNTINGTON BEACH EYE CLINIC & RESEARCH

7677 Center Ave., Suite 301, Huntington Beach, CA 92647
Phone: (714) 901-2007
*Diabetic Retinal Screening walk-in hours,
Monday-Friday 8:30-11:30 am & 1:30-4:20 pm



NEWPORT BEACH

361 Hospital Rd., Suite 425, Newport Beach, CA 92663
Phone: (949) 642-3100

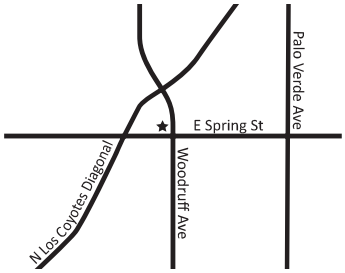


LAGUNA HILLS

23521 Paseo de Valencia, Suite 305, Laguna Hills, CA 92653
Phone: (949) 581-1770

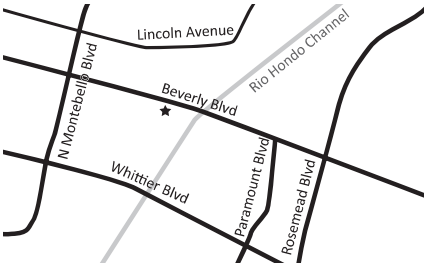
LONG BEACH

5991 E. Spring St., Long Beach, CA 90808
Phone: (562) 938-9945
*Diabetic Retinal Screening walk-in hours,
Monday-Saturday 8:30-11:30 am & 1:30-4:20 pm



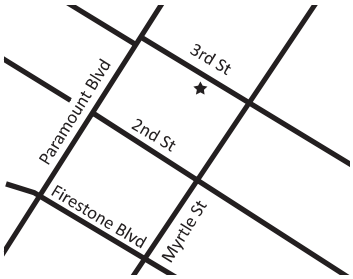
MONTEBELLO

229 E. Beverly Blvd., Montebello, CA 90640
Phone: (323) 728-7998
Clinic 2nd Floor & Surgery Center 1st Floor



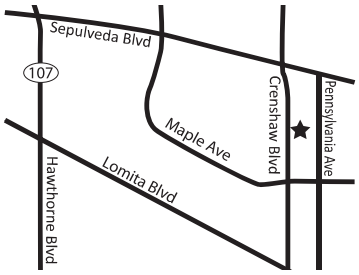
DOWNEY

8028 3rd St., Downey, CA 90241
Phone: (562) 622-8700
*Diabetic Retinal Screening walk-in hours,
Monday-Friday 8:30-11:30 am & 1:30-4:20 pm



TORRANCE

23000 Crenshaw Blvd., Suite 100, Torrance, CA 90505
Phone: (310) 803-9633



LOS ANGELES

231 W. Vernon Ave., Suite 104, Los Angeles, CA 90037
Phone: (310) 819-9500
*Parking in back of building on 43rd Place

HUNTINGTON BEACH LASER VISION CENTER

7677 Center Ave., Suites 102, Huntington Beach, CA 92647
Phone: (714) 316-0802
*Diabetic Retinal Screening walk-in hours,
Monday-Friday 8:30-11:30 am & 1:30-4:20 pm

POS Reorder # 1418060

Medical Information Form

ATLANTIS EYECARE

Patient's Name: _____ Birth Date: ____/____/____

Do you wear glasses or contact lenses? ❑ Yes ❑ No If Yes, for how long? _____

Please ✓ if any of the following apply to you and the date it first occurred:

MEDICAL PROBLEMS

Condition	Please ✓	Date
Alzheimers	❑ Yes ❑ No	
Arthritis	❑ Yes ❑ No	
Asthma/COPD/Bronchitis	❑ Yes ❑ No	
Cancer – type _____	❑ Yes ❑ No	
Diabetes – type _____	❑ Yes ❑ No	
High blood pressure	❑ Yes ❑ No	
Hepatitis/Jaundice	❑ Yes ❑ No	
Heart Disease	❑ Yes ❑ No	
Head Injury	❑ Yes ❑ No	
HIV positive/AIDS	❑ Yes ❑ No	
Kidney Disease	❑ Yes ❑ No	
Lupus	❑ Yes ❑ No	
Migraine Headaches	❑ Yes ❑ No	

Condition	Please ✓	Date
Rheumatic Fever	❑ Yes ❑ No	
Sarcoidosis	❑ Yes ❑ No	
Seizures	❑ Yes ❑ No	
Stroke	❑ Yes ❑ No	
Syphilis / Gonorrhea	❑ Yes ❑ No	
Thyroid Disease	❑ Yes ❑ No	
Tuberculosis	❑ Yes ❑ No	

Other Medical Problems (Please List)

_____

_____

_____

_____

_____

SURGICAL HISTORY

Have you had **general** surgery? ❑ Yes ❑ No

Please list:

Surgery	Date	Surgeon/Hospital

Have you had **eye** surgery? ❑ Yes ❑ No

Please list (including laser and lid surgery):

Surgery	Date	Surgeon/Hospital

MEDICATIONS *(Please List)*

Name	Dosage

Are you allergic to any medications, iodine, latex or anesthesia?

❑ Yes ❑ No If ***yes***, please list below:

_____

Do you require antibiotics prior to dental work or surgery?

❑ Yes ❑ No

FAMILY MEDICAL PROBLEMS

Do any family members have:	Please ✓	Relative
Glaucoma	❑ Yes ❑ No	
Macular Degeneration	❑ Yes ❑ No	
Diabetes	❑ Yes ❑ No	
Retinal Detachment	❑ Yes ❑ No	
Cataracts	❑ Yes ❑ No	
Amblyopia/Strabismus	❑ Yes ❑ No	
Other (list): _____		

SOCIAL HISTORY

Are you pregnant?	❑ Yes ❑ No
Do you smoke?	❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No
Do you drink caffeine?	❑ Yes ❑ No
Do you use illegal drugs?	❑ Yes ❑ No

This is to certify that, I the undersigned, consent to examination and treatment. This information and any photography may be used for scientific and educational purposes. I hereby authorize Atlantis Eyecare to furnish information to my insurance carrier, employer, referring physician, or other physician concerning my treatment and/or illness. I transfer assignment of all insurance benefits to Atlantis Eyecare for services, treatment, supplies or surgeries provided by physicians or staff. I understand that **I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.**

Patient Signature _____ **Date** _____

Medical Review Of Systems

ATLANTIS EYECARE

Patient Name _____ Birth Date _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

Check ☑ Yes boxes only. No need to check ❑ No boxes.

EYES

Loss of Vision	❑ Yes	❑ No
Loss of Side Vision	❑ Yes	❑ No
Distorted Vision or Halos	❑ Yes	❑ No
Fluctuating Vision	❑ Yes	❑ No
Flashes	❑ Yes	❑ No
Floaters	❑ Yes	❑ No
Eye Pain or Soreness	❑ Yes	❑ No
Light Sensitivity	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No
Crossing or Drifting of Eyes	❑ Yes	❑ No
Redness	❑ Yes	❑ No
Discharge	❑ Yes	❑ No
Foreign Body Sensation	❑ Yes	❑ No
Sandy or Gritty Feeling	❑ Yes	❑ No
Dryness	❑ Yes	❑ No
Itching	❑ Yes	❑ No
Burning	❑ Yes	❑ No
Excess Tearing/Watering	❑ Yes	❑ No
Glare	❑ Yes	❑ No
Styes	❑ Yes	❑ No
Other _____		

CONSTITUTIONAL

Fever	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No
Weight Gain	❑ Yes	❑ No

SKIN

Rashes or Color Changes	❑ Yes	❑ No
Itching or Dryness	❑ Yes	❑ No
Hair or Nail Changes	❑ Yes	❑ No

EARS, NOSE, MOUTH & THROAT

Hearing Difficulty	❑ Yes	❑ No
Ringing	❑ Yes	❑ No
Vertigo	❑ Yes	❑ No
Sinus Congestion	❑ Yes	❑ No
Runny Nose	❑ Yes	❑ No
Post-Nasal Drip	❑ Yes	❑ No
Nosebleeds	❑ Yes	❑ No
Dry Throat/Mouth	❑ Yes	❑ No
Hoarseness	❑ Yes	❑ No
Jaw Claudication	❑ Yes	❑ No

CARDIOVASCULAR

Chest Pain	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No
Other _____		

RESPIRATORY

Cough	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No

GASTROINTESTINAL

Swallowing Difficulty	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Nausea	❑ Yes	❑ No

GENITO-URINARY

Urinary Frequency	❑ Yes	❑ No
Urinary Pain or Blood	❑ Yes	❑ No
Males		
Discharge	❑ Yes	❑ No
Lesions or Masses	❑ Yes	❑ No
Females		
Currently Pregnant	❑ Yes	❑ No
Breast Masses	❑ Yes	❑ No
Breast Discharge	❑ Yes	❑ No
Vaginal Bleeding/Discharge	❑ Yes	❑ No

MUSCULOSKELETAL

Joint Pain	❑ Yes	❑ No
Joint Swelling	❑ Yes	❑ No
Redness	❑ Yes	❑ No
Muscle Pain	❑ Yes	❑ No
Muscle Cramps	❑ Yes	❑ No

NEUROLOGICAL

Headaches	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Tingling	❑ Yes	❑ No
Weakness	❑ Yes	❑ No
Paralysis	❑ Yes	❑ No
Fainting	❑ Yes	❑ No
Blackouts	❑ Yes	❑ No
Slurred Speech	❑ Yes	❑ No

PSYCHIATRIC

Anxiety	❑ Yes	❑ No
Depression	❑ Yes	❑ No
Other _____		

ENDOCRINE

Heat Intolerance	❑ Yes	❑ No
Cold Intolerance	❑ Yes	❑ No
Excessive Thirst	❑ Yes	❑ No
Excessive Hunger	❑ Yes	❑ No

HEMATOLOGICAL

Easy Bruising	❑ Yes	❑ No
Easy Bleeding	❑ Yes	❑ No
Blood Transfusions	❑ Yes	❑ No
Swollen Lymph Nodes	❑ Yes	❑ No

ALLERGY

Seasonal Allergies	❑ Yes	❑ No

Additional Notes/Comments:

Patient Registration Form

ATLANTIS EYECARE

PATIENT INFORMATION:

Last Name:	First Name:	MI:	Birth Date:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Email Address:	Age:	Sex ❑ M ❑ F	Social Security #
Occupation:	Employer:	Employer Phone:	
Employer Address:	City:	State:	Zip:
Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced	Spouse's Name:		
Spouse's Birth Date:	Spouse's Social Security #:	Spouse's Employer:	Phone Number:

PLEASE COMPLETE IF PATIENT IS UNDER AGE 18 OR A COLLEGE STUDENT:

Father's Last Name:	Father's First Name:	MI:	Father's Birth Date:
Father's Employer:	Father's Employer Phone:		
Father's Address:	City:	State:	Zip:
Father's Home Phone:	Father's Cell Phone:	Fathers' Social Security #:	
Mother's Last Name:	Mother's First Name:	MI:	Mother's Birth Date:
Mother's Employer:	Mother's Employer Phone:		
Mother's Address:	City:	State:	Zip:
Mother's Home Phone:	Mother's Cell Phone:	Mother's Social Security #:	

REFERRAL INFORMATION:

Name of Family Physician:	Name of Optometrist:
Were you referred here today by any of your physicians? If so, whom?:	

(Please complete back side)

ATLANTIS EYECARE

MEDICARE PATIENTS WHO HAVE PART B:

Medicare Number:	Effective Date:

1. Do you or your spouse work for a company that provides you with health insurance?	❑ Yes	❑ No
2. Are you entitled to Medicare because of disability or End-Stage Renal Disease?	❑ Yes	❑ No
3. Is the illness or injury the result of an automobile accident or other injury?	❑ Yes	❑ No
4. Has the treatment for the accident or illness been authorized by the Veteran's Admin?	❑ Yes	❑ No
5. Are you entitled to any benefits under the Federal Black Lung Program?	❑ Yes	❑ No

PRIMARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ No
Subscriber's Date of Birth:	Subscriber's Social Security #:

SECONDARY INSURANCE

Name of Insurance:	ID Number:
Employer:	Group Number:
Who is the subscriber:	Do you need a referral?: ❑ Yes ❑ No
Subscriber's Date of Birth:	Subscriber's Social Security #:

WORKMAN'S COMP. OR AUTO INSURANCE:

Where should bill be sent?:			Phone Number:
Address:	City:	State:	Zip:
Claim or Policy Number:			Date of Injury:

Patient Name: _____ **Date of Birth:** _____

Today's Date: _____

ATLANTIS
EYECARE

Patient Name: _____ **Date of Birth** _____

We ask the following questions for information gathering purposes only. The answers have no bearing on patient care.

1. Do you consider yourself to be Hispanic or Latino *(see definition below):*

❑ **Yes** ❑ **No**

(Hispanic or Latino – a person of Mexican, Puerto Rican, Cuban, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino")

2. What race do you consider yourself to be? *(if more than one race, select all that apply).*

❑ **American Indian or Alaska Native** *(a person having origins in any of the original peoples of North, Central or South America, and who maintain tribal affiliations or community attachment)*

❑ **Asian** *(a person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands)*

❑ **Black or African American** *(a person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American")*

❑ **Native Hawaiian or Other Pacific Islander** *(a person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands)*

❑ **White** *(a person having origins in any of the original peoples of Europe, the Middle East or North Africa)*

❑ **Uncertain**

ATLANTIS
EYECARE

NEW HIPAA PRIVACY REGULATIONS

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of Atlantis Eyecare will not reveal to any person personal information about you or about a family member (i.e. name, address, Social Security Number, as well as other health information) without permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation, or fundraising.

It is however understood, that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context.

- Patient Registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: verifications, Billing, paper and wire (including fax transmissions), Insurance company follow-up or interaction with billing services related to patient care
- Pursue collection of unpaid bills
- Hospital workers, nurses, aids, and medical records department
- Emergency officials, Paramedic, fire personnel, emergency room physicians, nurses or technicians
- Personal religious designate
- Pharmacists, drug program personnel/workers
- Completion of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

I AUTHORIZE THE RELEASE OF THIS NECESSARY INFORMATION

_____
Print Name

_____ _____
Signature of Patient or Representative Date

ATLANTIS EYECARE

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

Patient Authorization for Disclosure of Protected Health Information Form 7.31
This authorization allows the healthcare provider(s) named below to release confidential medical information records.
Note: *Information and records regarding treatment of minors, HIV psychiatric/mental health conditions or alcohol/substance abuse have special rules that require specific authorizations*.

Please print all information. Form must be signed and dated each year.

AUTHORIZATION:
I hereby authorize: _____ to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and /or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

Physician/Healthcare Facility Name

Patient Name:_____ **Date of Birth:** _____/_____/_____

Address: _____

City:_____ **State:** _____ **Zip:** _____

Entity Requested to Release Information:

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity that is to receive your PHI):

Individual/Entity Name: _____

Address: _____

Phone: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

❑ Entire patient record; or, check only those items of the record to be disclosed:

- ☐ Office notes
- ☐ Lab results
- ☐ X-rays;
- ☐ Financial history report (previous 3 years only).
- ☐ Only send the following: _____
- ☐ other outside physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment pathology reports ?

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
☐ Patient Request ☐ Other (please specify):_____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient or Representative Signature Date

You have the right to receive a copy of your signed authorizations upon request.

ATLANTIS EYECARE

LIFESTYLE VISION QUESTIONNAIRE

Name: _____ **Date** _____

We recognize that your eyes are very important to you. We would like to know how *you* use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.

- Do you wear glasses now? ❑ No ❑ Yes
  If Yes, how often? ❑ All the time ❑ Sometimes
  ❑ Only for distance ❑ Only for reading ❑ Only for computer
- How important is it for you to see to read or use computer without glasses?
  ❑ Very important ❑ Important ❑ Somewhat important ❑ Not important
- If it were possible to go without glasses for most of the time, would you like that?
  ❑ No ❑ Yes
- How many hours per day do you: Read?_____ hrs Use computer?_____ hrs
- Do you drive at night? ❑ Socially ❑ Occasionally ❑ Often

CHECK the following activities you do on a regular basis:

❑ Read books	❑ Play Cards / Dominos	❑ Drive daytime
❑ Read medicine bottles	❑ Paint / Artist	❑ Drive nighttime
❑ Needlepoint / Crochet	❑ Cook	❑ Golf
❑ Dine in Restaurant	❑ Musician	❑ Hunt / Fish
❑ Shopping	❑ Computer / Tablet	❑ Bicycling, Hiking etc.
❑ Photography	❑ Cell phone	❑ Tennis
❑ Other _____		❑ Spectator Sports

Please circle on the following scale to describe your personality as best you can:

1 2 3 4 5 6 7 8 9 10

Easy going Perfectionist