NEW PATIENT INFORMATION

Name:_____ Birthdate:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____ work #_____

Preferred Contact Method:_____ Email Address:_____

SSN#: XXX-XX-_____ Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Referring Physician:_____ Primary Physician:_____

Race: Caucasian Hispanic Asian African-American Other

Ethnicity: Not of Hispanic Origin Hispanic Origin Preferred Language _____

INSURANCE INFORMATION

(We do not accept covered California policies)

Primary Insurance:_____ ID# _____ Group#_____
Subscriber Name:_____ DOB:_____ SSN:_____
Relationship:_____
Secondary Insurance:_____ ID# _____ Group# _____
Subscriber Name: _____ DOB: _____ SSN: _____
Relationship: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including MediCare, private insurance and any other health plan to Craig E. Berris, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original, I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event of default, I agree to pay all collection cost and/or attorney fee's. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____ Date: _____

MISSED APPOINTMENT/UNTIMELY CANCELLATION POLICY

Our office has scheduled your appointment time and we are delighted to have you as a patient. This time has been set aside just for you and our other patients were asked to schedule their appointment at a later date. Most of our patients are very considerate in contacting our office if they are unable to keep their appointment. If you're unable to keep your appointment, please notify us at least one working day ahead so that we might be able to offer that time to others. If you miss your appointment without timely notification, we reserve the right to apply a $50 No-Show Fee.

Signed: _____ Date: _____

PHOTO RELEASE

I give my permission for any photographs taken during my course of treatment to be used as Dr. Berris deems necessary for documentation and/or educational purposes.

Signed: _____ Date: _____

PLEASE COMPLETE THIS FORM

Current Medications: <u>If more than 10 medications, Please Attach List</u>

[] NONE

	Medication Name	Dose
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____

Medication Allergies:

[] NONE

	Medication Name	Reaction
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Name of Pharmacy:

Name:_____
Address:_____
Phone #:_____

Height:_____(inches) Weight:_____(lbs)

Pneumococcal Vaccine Yes_____ No_____

Smoking History: []Current every day smoker []Current some day smoker []Former smoker []Never smoked

Alcohol History: []No Alcohol Use [] Alcohol Use Socially [] Alcohol Use Daily

Do you wear distance Glasses or Contacts? Yes / No

PLEASE COMPLETE THIS FORM

PREVIOUS Eye Procedure: [] NONE

[] Brow Lift	[] Right [] Left	Date:_____
[] Ptosis Repair	[] Right [] Left	Date:_____
[] Blepharoplasty, Upper	[] Right [] Left	Date:_____
[] Blepharoplasty, Lower	[] Right [] Left	Date:_____
[] Correction of Lid Retraction	[] Right [] Left	Date:_____
[] Dacryocystorhinostomy	[] Right [] Left	Date:_____
[] Ectropian Repair	[] Right [] Left	Date:_____
[] Entropian Repair	[] Right [] Left	Date:_____
[] Orbital Decompression	[] Right [] Left	Date:_____
[] Cataract Surgery	[] Right [] Left	Date:_____
[] Lasik Surgery	[] Right [] Left	Date:_____
[] Trabeculectomy	[] Right [] Left	Date:_____
[] Other:_____	[] Right [] Left	Date:_____

PREVIOUS Surgeries: [] NONE

Surgeries/Hospitalizations:	Date(s)	Anesthesia Complications
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____

CURRENT MEDICAL PROBLEMS

[] Good General Health	[] Chalazion	[] COPD	[] Dialysis	Neurologic Disease
[] High Blood Pressure	Ear/Nose/Throat	[] Bronchitis	[] BPH	[] Bell's Palsy
[] Elevated Cholesterol	[] Loss of hearing	[] Emphysema	[] Prostate Cancer	[] Migraines
Eye Diseases	[] Tinnitis	[] Sleep Apnea	Female Questions	[] Memory Loss
[] Dry Eyes	[] Nose Bleed	[] CPAP Machine	[] Pregnant	[] Dementia
[] Constant Tearing	[] Sinus Problems	GI Disease	[] Nursing	[] Neuromuscular Disease
[] Eye Infection	Cardiovascular Disease	[]Ulcers	[] Post-Menapausal	[] Myasthenia
[] Thyroid Eye Disease	[] Heart Attack	[] Spastic Colon	[] Breast Cancer	[] Stroke or Paralysis
[] Loss of Vision	[] Heart Failure	[] Diverticulosis	Bone and Joint Disease	[] Seizures
[] Macular Degeneration	[] Pedal Edema	[] Colon CA	[] Arthritis	Psychiatric
[] Amblyopia	[] Aneurysm	[] Gallbladder	[] Back Problems	[] Depression
[] Blindness	[] Heart Murmur	[]Cirrhosis	[] Fracture	[] Anxiety
[] Glaucoma	[] Mitrovalve Prolapse	[] Liver Disease	Hematologic Disease	Skin Disease
[] Cataract	[] Heart Bypass	[] Hepatitis B	[] Bleeding Disorder	[] Rosacea
[] Aphakia w/IOL	[] Heart valve replace	[] Hepatitis C	[] Hemaphilla	[] Skin Cancer
[] Eye Injury	[] Arrythmia	[] Pancreatitis	[] Blood Transfusion	[] Keloid
[] Enucleation	[] Atrial Fib	[] Hernia	[] Anemia	Miscellaneous
[] Iritis/Uveitis	[] Pacemaker	Genito-Urinary Disease	[] Blood Clots	[] Cancer_____
[] Diabetic Retinopathy	[] Defibrillator	[] Kidney/Bladder Infect	Endocrine Disease	[] Motion Sick or P/O Nausea
[] Retinal Disease	Lung Disease	[] Blood in Urine	[] Diabetes	[] Cold Sores
[] Retinal Detachment	[] Asthma	[] Kidney Disease	[] Hyperthyroidism	[] HIV
[] Strabismus	[] Pneumonia	[] Kidney Stones	[] Grave's Disease	[] Latex Allergy
[] Diplopia	[] TB	[] Renal Failure	[] Hypothyroidism	