New Patient Questionnaire and Medical History Form

Today's date: _____

Patient name: _____

Date of birth (MM/DD/YYYY): _____

Gender: ☐ **Female** ☐ **Male** ☐ **Non-binary** ☐ **Other**

Address: _____

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

Primary phone number: _____ ☐ **Home** ☐ **Cell**

Additional phone number: _____ ☐ **Home** ☐ **Cell**

Marital status

☐ **Married** ☐ **Single** ☐ **Other**

Emergency contact information

Emergency contact name: _____

Phone number: _____ **Relationship to patient:** _____

Primary care information

Name of primary care doctor, nurse practitioner, or physician assistant: _____

Pharmacy information

Name of pharmacy and cross streets: _____

Insurance information

Primary insurer: _____ **Policy number:** _____

Secondary insurer: _____ **Policy number:** _____

Immunization history

Have you had a flu shot this year?	☐ Yes	☐ No, for medical reasons	☐ No, for non-medical reasons
Have you been vaccinated against COVID-19?	☐ Yes	☐ No, for medical reasons	☐ No, for non-medical reasons
Have you had a Pneumococcal vaccination (e.g., Pneumovax)?	☐ Yes	☐ No, for medical reasons	☐ No, for non-medical reasons

Communication preferences

Do you agree to communicate with Dr. Tapadia and the staff at Tapadia Eye Care **by email and standard text messages** regarding various aspects of your medical care? This may include, but is not limited to: test results, prescriptions, and billing.

By agreeing, you understand that **email and standard text messages** are not confidential methods of communication, and they may be insecure. Because of this, there is a risk that email and standard text messaging regarding your medical care might be intercepted and read by a third party.

We offer all our patients a secure online patient portal through www.myPatientVisit.com.

Please note that, regardless of your preference, you will receive appointment reminders by text message and/or voicemail.

☐ **I agree to communicate with Tapadia Eye Care by email and text message.**

My email address is: _____

☐ **I do not agree.** I prefer to communicate with Tapadia Eye Care using secure means only.

Medical History Questionnaire

In a few words, what brings you in today? _____

_____

How long have you had these symptoms/problems? _____

Eye history

Do you wear glasses? ☐ Yes ☐ No **For reading, distance, or both?** _____

How old are your eyeglasses? _____

Do you wear contacts? ☐ Yes ☐ No **Do you sleep in them?** ☐ Yes ☐ No

Do you have, or have you ever been treated for, any of the conditions listed below?

Condition	✓	Condition	✓
Dry eyes	____	"Lazy"/crossed eye	____
Macular degeneration	____	Herpetic eye disease	____
Glaucoma	____	Shingles of the eye	____
Cataract	____	Diabetic eye disease	____
"Stroke" of the eye	____	Keratoconus	____
Retinal tear/detachment	____	Fuchs' dystrophy	____
Uveitis/iritis	____	Bell's palsy	____
Scleritis	____	Pterygium	____

Please list any other eye conditions not listed above: _____

_____

Have you ever had LASIK or other refractive eye surgery? ☐ Yes ☐ No

Have you ever had any other eye surgeries? ☐ Yes ☐ No

If yes to either of the above, please list your eye surgeries and their approximate dates:

_____

Please list your current eye drops, including their names, how often you use them, and in which eye(s):

_____

Medical history

Do you have, or have you ever been treated for, any of the conditions listed below?

Condition	✓	Condition	✓	Condition	✓
High blood pressure		Kidney disease		Migraines	
Coronary artery disease (CAD)		Liver disease		Seizures	
Congestive heart failure		Rheumatoid arthritis		Sleep apnea	
Heart murmur		Sjogren's syndrome		Bleeding disorder	
Stroke/mini stroke		Ankylosing spondylitis		Rosacea	
Type 1 diabetes		Lupus		Dementia	
Type 2 diabetes		Stomach ulcers		Organ transplant	
High cholesterol		Asthma		Cancer	
Thyroid disease		COPD/emphysema			

If you have diabetes, what was your last A1c? _____ **What is your usual fasting blood sugar?** _____

Please list any other health conditions not listed above: _____

Surgical history

Please list any surgeries you have had and their approximate dates: _____

Current medications

Please list all medications you currently take, including any supplements.

_____

_____

_____

_____

_____

Allergies and intolerances

Are you allergic to any medications or substances? ☐ **Yes** ☐ **No**

Please list allergies or intolerances to any medications or other substances.

Medication/substance	Reaction

Family medical history

Have any of your blood relatives had or been treated for any of the following conditions?
This includes parents, siblings, children, aunts/uncles, and grandparents.

Condition	✓	Relationship	Condition	✓	Relationship
Heart problem	___	_____	Macular degeneration	___	_____
Rheumatoid arthritis	___	_____	Glaucoma	___	_____
Other autoimmune disease	___	_____	Corneal disease	___	_____
Stroke	___	_____	Retinal detachment	___	_____
Cancer	___	_____	"Lazy"/crossed eye	___	_____
			Uveitis	___	_____

Please list any other health conditions not listed above: _____

_____

Social history

Do you currently use tobacco? ☐ Yes ☐ No

Have you previously used tobacco? ☐ Yes ☐ No

How often do you drink alcohol? ☐ Never ☐ Occasionally ☐ Often ☐ Daily

Do you use street/illicit drugs? ☐ Yes ☐ No

If so, what type? _____

Are you currently pregnant, or is there a possibility that you could be pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Consent to Treatment · Patient Privacy Information · Clinic Policies

1. **General consent for testing, treatment, and medical services: By signing below, I consent to receive medical care with Tapadia Eye Care**. I understand that any treatments and procedures performed at Tapadia Eye Care will be administered by a physician in accordance with state laws and appropriate medical licensure.

2. **Consent to release health information:** I understand this Clinic uses an electronic medical record (EMR). I understand that the EMR contains information about my health from my past, current, and future medical care. I agree that this health information may be released through Tapadia Eye Care's EMR or by other means (for example, by fax, telephone, email, or hand delivery) in the following ways: 1) to Tapadia Eye Care; 2) to my past, current, and future health care doctors/providers and other health care organizations that provide care to me; or 3) to the entities named in my medical record who pays for my treatment, such as an insurer or guarantor. These people or organizations may use my health information: 1) to provide medical care to me; 2) to get paid for my treatment; or 3) to perform activities relevant to health care operations (for example, managing my care, providing quality care, or completing patient safety activities). I understand that these people or organizations will have access to relevant portions of my medical record, and that this may include information regarding behavioral health or substance use disorder information (for example, drug and alcohol treatment); my medical history, diagnoses, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease-related information (for example, sexually transmitted diseases), and/or HIV/AIDS-related information. I understand that I may revoke this consent at any time, except if my health information has already been released to another person or organization. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death**.**

3. **Consent for electronic prescribing (e-prescribing):** I understand that Tapadia Eye Care may use an electronic prescription system, which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I understand that my doctors and medical providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other doctors and providers. **By signing below, I give my consent to my doctors and medical providers to see this protected health information.**

4. **Notice of Privacy Practices:** Pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of Tapadia Eye Care's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This may include my protected health information generated during outpatient treatment at Tapadia Eye Care, and this information may include but is not limited to information regarding mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, or genetic testing.
   By signing below, I affirm that I have received, read, and understood the Notice of Privacy Practices, which sets forth Tapadia Eye Care's privacy practices and my rights regarding the privacy of my health information.

5. **COVID-19 policy: By signing below, I affirm that I understand and agree to follow Tapadia Eye Care's policies regarding COVID-19, including:**
   - If asked, I agree to wear a mask that fully covers my mouth and nose at all times while in the office of Tapadia Eye Care.
   - I understand that the following types of masks are not permitted: mesh masks; valved masks that freely allow air to flow out from my nose or mouth; and bandana-style masks that do not tuck under the chin.
   - I will not enter the office if I have symptoms of COVID-19, regardless of my vaccination status. I understand that, if I am having such symptoms, I should call the office to reschedule my appointment.
   - I understand that these policies also apply to any caregivers I bring with me to appointments.

6. **Consent to clinic photos/videos:** I consent to the photographing and/or videotaping of the parts of my body that are relevant to my medical condition and medical care strictly for medical record documentation purposes, provided that said photographs or videos are maintained and released in accordance with protected health information regulations. I understand that I will be informed if and when such photography/videotaping takes place.

7. **Cancellation and No-Show Policy**: **Tapadia Eye Care requires advance notice of at least 24 hours to cancel or reschedule appointments. If I no-show to my first appointment, I understand that I will not be rescheduled.** If I do not provide adequate notice, or if I NO-SHOW to a followup appointment, I understand that I will be charged a fee of $40 per occurrence. I understand that three or more no-shows may result in my dismissal from the practice. **By signing below, I acknowledge that I have read this notice and understand the Cancellation and No-Show Policy for Tapadia Eye Care.**

8. **Late Arrival Policy: Tapadia Eye Care allows a 15-minute "grace period" for all appointments.** If I am more than 15 late for my appointment, I understand that I may be marked a "no-show," my appointment may be relinquished, and I may be required to reschedule my appointment. **By signing below, I acknowledge that I have read this notice and understand the Late Arrival Policy for Tapadia Eye Care.**

9. **Promise to pay: By signing below, I affirm that I understand that I am financially responsible for my account with Tapadia Eye Care in accordance with the regular rates and terms of the practice.** I understand and accept full responsibility for the payment of services rendered to me by Tapadia Eye Care, and I agree to pay for them in full, at the time of service, unless other arrangements have been made in advance. I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance. If I fail to remit payment when due, and the account becomes delinquent or is turned over to a collection agency or attorney for payment collection, I agree to pay all collection fees, court costs, and attorney's fees. I also agree that any patient or guarantor overpayments made on my account may be applied directly to any delinquent account for which my guarantor or I am legally responsible at the time of the collection of the overpayment.

10. **Financial Policy:** By signing below, I affirm that I have received, read, and understood the Financial Policy Form, which sets forth Tapadia Eye Care's financial policies.

11. **Videotaping/recording policy:** I understand and agree not to take photographs, videos, or audio recordings, or to otherwise capture imaging or sound on any device while I am at Tapadia Eye Care. I agree not to capture audio recordings of my communications with Tapadia Eye Care. I also understand that it is my responsibility to ensure that those accompanying me on my visits to Tapadia Eye Care comply with this requirement.

12. **Open payments disclosure:** The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

13. **Medical Board of California disclosure:** Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint, go to www.mbc.ca.gov, email licensecheck@mbc.ca.gov, or call (800) 633-2322.

By signing below, I acknowledge and agree to follow the above clinic policies and procedures.

Signature of patient or legal guardian: _____ Date: _____

Print name: _____ Relationship to patient: _____

Refraction Policy

What is a refraction?
A refraction is an examination technique to check the prescription of your eyeglasses.

Why is it performed?
Refraction is sometimes performed to determine the cause of a patient's blurred vision. Refraction can help differentiate whether the blurred vision is due to the need for eyeglasses, or due to another medical problem.

What is the cost?
Most medical insurance plans, including Medicare, do not cover refractions.

As a result, we charge a **$40 refraction fee** to perform a refraction, since it is not a covered service under medical insurance plans. **We only charge this fee when we perform the refraction.**

Will you bill my insurance?
We will not bill your insurance for your refraction, as it is considered a non-covered service. (Exception: patients with Medi-Cal/CalOptima as their primary insurance.)

If you have any questions regarding the policies and procedures of your insurance plan, please do not hesitate to ask. We will do our best to assist you.

By signing below, I acknowledge and agree to the Refraction Policy.

Signature of patient or legal guardian: _____ Date: _____

Print name: _____ Relationship to patient: _____