

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 every day. This information will help us provide you with the most effective care, we ask that you bring the following with you to your initial appointment.

- Do you wear glasses now? No Yes
 - All the time
 - Only for distance
 - Sometimes
 - Only for reading
- How important is it for you to see to read or use computer without glasses?
 - Very important
 - Important
 - Somewhat important
- If it were possible, would you like to have contact lenses?
 - Yes
 - No
- How often do you use contact lenses?
 - Daily
 - Sometimes
 - Only for special occasions
 - Never

Medical Information Form

Patient's Name: _____ Birth Date: _____
 Do you wear glasses or contact lenses? Yes No If yes, for how long? _____
 Please check if any of the following apply to you and the date it first occurred:

Condition	Please /	Date	Condition	Please /	Date
Alzheimer's	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Sarcoidosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma/COPD/Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer - type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes - type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			



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 other than those named below any information that is protected by the Privacy Rule. This information will never be shared with any other person, including family members (i.e. name, address, Social Security Number, etc.).

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



Patient Registration Form

PATIENT INFORMATION:

Last Name:		First Name:		MI:	Birth Date:	
Address:		City:		State:	Zip:	
Home Phone:		Cell Phone:				
Email Address:		Age:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #		
Occupation:	Employer:	See	Employer Phone:			
Employer Address:	City:	State:	Zip:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> 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 Employer:	
Father's Address:	
Father's Home Phone:	
Mother's Last Name:	
Mother's Employer:	
Mother's Address:	
Mother's Home Phone:	

REFERRAL INFORMATION:

Name of Family Physician: _____
 Where you referred here today by any of your physicians: _____



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")

(If more than one race, select all that apply.)
 Do you have any ancestry or tribal affiliation (other than your own) that you would like to maintain tribal affiliations or community attachment from the original peoples of the Far East, Southeast Asia or the Pacific, Cambodia, China, India, Japan, Korea, Malaysia, or other Pacific Islander?

Do you have any ancestry or tribal affiliation (other than your own) that you would like to maintain tribal affiliations or community attachment from the original peoples of the black racial groups of Africa?

Do you have any ancestry or tribal affiliation (other than your own) that you would like to maintain tribal affiliations or community attachment from the original peoples of Europe, the Middle East or North Africa?

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
- Current prescription of eye glasses or contacts (contact box)
- 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
- (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 to your appointment.

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

7777 Edinger Ave., Ste. 254 • Huntington Beach, CA 92647
 2475 S. Baseline Blvd., Ste. 120 • Anaheim, CA 92805
 8212 E. Florence Ave. • Downey, CA 90240
 2077 Center Ave., Ste. 301 • Huntington Beach, CA 92647
 23521 Paseo de Valencia, Ste. 305 • Laguna Hills, CA 92653

5995 E. Spring St. • Long Beach, CA 90809
 361 Hospital Rd., Ste. 425 • Newport Beach, CA 92663
 1840 W. 9th St., Ste. 225-9 • San Pedro, CA 90732
 22525 Mulden Ave., Ste. 100 • Torrance, CA 90509