ATLANTIS EYECARE

LIFESTYLE VISION QUESTIONNAIRE

Name: _____ Date _____

We recognize that your eyes are very important to you. We would like to know t
daily basis. Along with your eye exam, this info will assist us in recommending t
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
- How important is it for you to see to read or use computer without glasses?
  ❑ Very important ❑ Important ❑ Somewhat important ❑ Not im
- If it were possible to go without glasses for most of the time, would you like t
  ❑ No ❑ Yes
- How many hours per day do you: Read?_____ hrs Use computer?_____ h
- Do you drive at night? ❑ Socially ❑ Occasionally ❑ Often

CHECK the following activities you do on a regular basis:

❑ Read books	❑ Play Cards / Dominos	❑ Dri
❑ Read medicine bottles	❑ Paint / Artist	❑ Dri
❑ Needlepoint / Crochet	❑ Cook	❑ Goli
❑ Dine in Restaurant	❑ Musician	❑ Hun
❑ Shopping	❑ Computer / Tablet	❑ Bicy
❑ Photography	❑ Cell phone	❑ Ten
❑ Other _		

Please circle on t
1
Easy going

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Medical Information Form

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	
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):

MEDICATIONS *(Please List)*

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 <u>not</u> 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
  billing services related to patient care

ical records department
onnel, emergency room physicians, nurses or

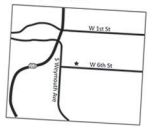
Nine Locations Serving Orange County and Los Angeles

ATLANTIS EYECARE

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

SAN PEDRO
1360 W. 6th St., North Bldg., Suite 125
San Pedro, CA 90732
Phone: (310) 359-1290



RETINA, LASIK & COSMETIC INSTITUTE*
7777 Edinger Ave., Suite 234
Huntington Beach, CA 92647
Phone: (714) 901-2006
*Office next to Bed, Bath & Beyond

DOWNEY
8311 E. Florence Ave.
Downey, CA 90240
Phone: (562) 622-8700

TORRANCE
22525 Maple Ave., Suite 100
Torrance, CA 90505
Phone: (310) 803-9633

POD Reorder # 1418000

ATLANTIS EYECARE

Patient Registration Form

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:			

REFERRAL INFORMATION:

Name of Family Physician:

Were you referred here today by any of y

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)
- 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

www.atlantiseyecare.com

POD Reorder # 1418052

ATLANTIS EYECARE

❑ Retina, Lasik & Cosmetic Institute
7777 Edinger Ave., Ste. 234 • Huntington Beach, CA 92647
❑ 947 S. Anaheim Blvd., Ste. 120
Anaheim, CA 92805
❑ 8311 E. Florence Ave.
Downey, CA 90240
❑ 7677 Center Ave., Ste. 301
Huntington Beach, CA 92647
❑ 23521 Paseo de Valencia, Ste. 305
Laguna Hills, CA 92653
❑ 5991 E. Spring St.
Long Beach, CA 90808
❑ 361 Hospital Rd., Ste. 425
Newport Beach, CA 92663
❑ 1360 W. 6th St., Ste. 125-N
San Pedro, CA 90732
❑ 22525 Maple Ave., Ste. 100
Torrance, CA 90505

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,*

person having origins in any of the black racial groups of r "Negro" can be used in addition to "Black" or "African

cific Islander (a person having origins in any of the original or other Pacific Islands)

in any of the original peoples of Europe, the Middle East or

POD Reorder # 1418056