DAVIDORF Eye Group
FREEDOM IN SIGHT

Dr. Jonathan Davidorf, MD/Dr. Douglas Gellerman, MD/ Dr. Debra Tennen, MD/ Dr. Guy Massry, MD/ Dr. Michelle Vartanian, OD/ Dr. Jasmine Lynn, OD

PATIENT REGISTRATION

Today's Date: ___ / ___ /___ Referred by:* _____

Legal First Name: *_____ Legal Last Name:* _____

Nickname/Preferred Name: _____ Gender:* ☐ Male ☐ Female

Date of Birth:* ___ / ___ /___ If minor, name of parent/legal guardian: _____

Race:*_____ Language: _____ Social Security #: ___ - ___ - ____

Home Phone:* (___) _____ Cell Phone:* (___) _____ Email: _____

Primary Contact Method (Circle one):* Home / Cell / Email

Address:*_____ City:*_____ Zip Code:*_____

Living Arrangements (Circle one): With Spouse/Kids / With Parents / Alone / Other:_____

Preferred Physician (Circle one): * Dr. Davidorf / Dr. Gellerman / Dr. Tennen

Dr. Vartanian / Dr. Lynn / Dr. Massry

Marital Status (Circle one): Single / Married / Other

Emergency Contact Name: _____ Phone #: _____

Name of Primary Care Physician: _____ Phone #: _____

Name of Optometrist: _____ Phone #: _____

Name of previous eye doctor: _____ Phone #: _____

Employer/Occupation: _____ Phone #: _____

Pharmacy Name/Location: _____ Phone #: _____

MEDICAL INFORMATION

CHIEF COMPLAINT: What eye problems are you currently experiencing? **

_____

_____

Are you allergic to any of the following? (Circle all that apply): *

Penicillin / Aspirin / Codeine / Latex / Sulfa List any others: _____

Please list all medications, pills and/or eye drops you are presently taking (you can :

_____

_____

Past Ocular History:

Do you have or had any of the following conditions and/or surgeries in the past? Please circle YES or NO

Macular Degeneration	YES	NO
Retinal Detachment	YES	NO
Cataract	YES	NO
Cataract Surgery	YES	NO
Dry Eye	YES	NO
Eye Inflammation	YES	NO
Eye Injury	YES	NO
Glaucoma	YES	NO
Glaucoma Surgery	YES	NO
Lazy Eye (Amblyopia)	YES	NO
Crossed Eye (Strabismus)	YES	NO
LASIK/PRK		

Other (Please list): _____

Past Medical History:

During the past year, have you been under the care of a physician? If yes, list reasons why:

_____

_____

Past Surgical History:

Please list all surgical procedures you have had:

_____

_____

Family History (Please check all that apply and indicate relationship):

Amblyopic	( )
Blindness	( )
Cataracts	( )
Crossed eyes (Strabismus)	( )
Diabetic retinopathy	( )
Glaucoma	( )
Macular degeneration	( )
Retinal detachment	( )
Cancer	( )
Diabetes	( )
Heart disease	( )
High blood pressure	( )
Stroke	( )

Social History:

Smoking Status:
Never smoked ( )
Former smoker ( )
Occasional smoker ( )
Current every day smoker ( )

Alcohol:
Rarely ( ) for _____years
Socially ( ) _____drinks/day
_____drinks/week

Driving Status (Please check one): ☐ With Limitations ☐ No limitations

Review of Systems (Please check all that apply):

Constitutional: fever ( ) weight loss ( )

Eyes: blurred vision ( ) double vision ( )

Ear/Nose/Throat: hearing loss ( ) sinus problems ( )

Cardiovascular: chest pain ( ) irregular heartbeats ( )

Respiratory: shortness of breath ( ) wheezing ( )

Gastrointestinal: abdominal pain ( ) nausea ( )

Genitourinary: blood in urine ( ) discomfort ( )

Musculoskeletal: joint pain( ) low back pain ( )

Integumentary skin/breast: rashes ( ) skin tumors ( )

Neurological: numbness ( ) weakness ( )

Psychiatric: anxiety ( ) depression ( )

Endocrine: heat intolerance ( ) thyroid problems ( )

Hematologic/Lymphatic: anemia ( ) unusual bleeding ( )

Allergic/Immunologic: hives ( ) seasonal allergies ( )

Insurance Information

Primary Insurance

CO_____**ID#**_____**GROUP#**_____

Secondary Insurance

CO_____**ID#**_____**GROUP#**_____

Vision Insurance

CO_____**ID#**_____**GROUP#**_____

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DAVIDORF EYE GROUP. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SEVICES. I UNDERSTAND THAT THE INITIAL INSURANCE INFORMATION GIVEN BY ME WILL BE BILLED AND DAVIDORF EYE GROUP WILL NOT REBILL OTHER INSURANCE AFTER MY DATE OF SERVICE.

SIGNED: _____**DATE:**_____

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Dear Patient:

In general, medical insurance carriers cover procedures, devices, etc. they consider medically necessary. Listed below are some of the more common items NOT typically covered by medical insurance.

Refraction

A measurement taken to determine your eyeglass prescription. Medicare and most private insurance plans do not pay for the refraction and require that we collect this fee at the time of service. Some HMO insurance and certain vision plans pay for the refraction. The cost of the refraction is $50.00.

Contact Lens Fitting

To ensure the best possible prescription, a fitting and evaluation will be performed for patients requesting contact lenses or a written prescription for contact lenses. The fitting fee will be applicable when requesting a different prescription or change in type of contact lenses.

LASIK

Laser vision correction is typically considered an elective procedure and not covered by insurance carriers.

Multifocal/Accommodative Lenses

As an option to the monofocal lens, multifocal and accommodative lenses implanted during cataract surgery often eliminate the need for glasses following cataract surgery. These lenses are considered elective by most insurance carriers.

Cosmetic Eyelid Procedures (Blepharoplasty, Botox, Brow Lifts)

These items are usually considered cosmetic. They are covered by insurance if they are medically indicated.

Latisse

A prescription medication which facilitates eyelash growth. This is considered cosmetic and not a medical necessity.

Co- Pay

Co-pay is due at end of the visit, if not paid at the time there will be an additional $25.00 billed to the patient, in addition to the co-pay.

I understand that insurance does not typically cover the items detailed on this page.

_____ _____

Patient Signature **Date**

_____

Patient Name

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West Hills, California 91307
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www.davidorf.com

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Bernard Davidorf, M.D.
Jonathan Davidorf, M.D.
Douglas Gellerman, M.D.
Guy Massry, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Name of Patient: _____

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please specify)_____

_____ Date_____