



Nicole Fram MD Sahar Bedrood MD, PhD Tiffany Shahrooz MD  
Christina Moghadam, OD Soseh Markarian, OD

## PATIENT INFORMATION FORM

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ Gender \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE and ZIP \_\_\_\_\_

CELL PHONE \_\_\_\_\_

HOME PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_

REFERRING DOCTOR/PERSON: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

CURRENT OCCUPATION: \_\_\_\_\_

### INSURANCE INFORMATION – Fill out below if card is not present

PRIMARY: \_\_\_\_\_

SUBSCRIBER NAME & DOB: (if not yourself) \_\_\_\_\_

SECONDARY: \_\_\_\_\_

SUBSCRIBER NAME & DOB: (if not yourself) \_\_\_\_\_

### EMERGENCY CONTACT

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

### BEST WAY TO CONTACT

PHONE  TEXT  EMAIL

Have you ever been told you have dry eyes?  Yes  No When? \_\_\_\_\_ Which Eye or both? \_\_\_\_\_

Do you have any of the following symptoms?

- Redness
- Burning
- Itching
- Light sensitivity
- Excess tearing/watering eyes
- Tired eyes, eye fatigue
- Stringy mucus discharge
- Foreign body sensation
- Contact lens discomfort
- Scratchy feeling of sand /gritty feeling

Have you had any of the following surgeries?

Cataract YES/NO    Glaucoma YES/NO    Refractive surgery YES/NO

Do you use?

- Contact lenses
- Restasis
- Rx eye drops for allergy (e.g., anti-inflammatory, antihistamine)
- Rx eye drops for Glaucoma (e.g., Xalatan, Timolol)
- Over the counter eye drops such as artificial tears?
- Nutritional supplements (e.g., flaxseed oil, omega-3)

Are your symptoms related to the following conditions?

- Windy Conditions
- Places with low humidity (e.g., airplanes/hospital)
- Areas that are air conditioned/heated

Are you taking any of the following medications?

- Antihistamines/Decongestants
- Antidepressant or anti-anxiety
- Accutane or other oral treatment for acne
- Hormone Replacement Therapy
- Antihypertensive (e.g., Diuretic.)

## Medical History Questionnaire

**Reason For Visit-** *(Include which eye); Examples: blurred vision, dry eyes, cataract, cornea or glaucoma evaluation, pain, redness, tearing*

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**How long have you been experiencing these symptoms?** \_\_\_\_\_

**Review**

**of Systems:** *Are you currently receiving treatment or have previously been treated for any of the following conditions?*

<b>Fever/Weight Loss</b> Other – Please Specify	
<b>Eyes</b> Glaucoma / Cataract / Lazy Eye / Retina Problems / LASIK or Laser Vision Correction / Other – Please Specify	
<b>Cardiovascular</b> Heart Problems / Chest Pain / Irregular Heart Beat / High Blood Pressure / High Cholesterol / Other – Please Specify	
<b>Respiratory</b> Asthma / Shortness of Breath / Wheezing / Coughing / Other – Please Specify	
<b>Gastrointestinal</b> Heartburn / Abdominal Pain / Diarrhea / Vomiting / Other – Please Specify	
<b>Integumentary</b> Skin Rashes / Excessive Dryness / Other – Please Specify	
<b>Musculoskeletal</b> Muscle Aches / Joint Pain / Swollen Joints / Other – Please Specify	
<b>Neurological</b> Numbness / Weakness / Headaches / Other – Please Specify	
<b>Hematologic/Lymphatic</b> Blood Disorders / Leukemia / Other – Please Specify	
<b>Allergic/Immunologic</b> Hay Fever / Allergies / Other – Please Specify	
<b>Endocrine</b> Hypothyroid / Hyperthyroid / Thyroid Disease Autoimmune Disease / Other – Please Specify	
<b>Psychiatric</b> Depression / Anxiety / Other – Please Specify	

**Past Surgeries** - *List any surgeries on major organs, excluding procedures for the eyes:* \_\_\_\_\_

**Family History:** Do any of the following medical or eye diseases run in your Family? If YES, please circle and note the relationship to you below

Ocular		Explanation/Relationship
Cataract at a Young Age	[No] _____	[Yes] _____
Glaucoma	[No] _____	[Yes] _____
Macular Degeneration	[No] _____	[Yes] _____
Retinal Detachment	[No] _____	[Yes] _____

Medical		
Diabetes	[No] _____	[Yes] _____
Hypertension	[No] _____	[Yes] _____
Heart Disease	[No] _____	[Yes] _____
Stroke	[No] _____	[Yes] _____
Arthritis, Lupus, Rheumatoid Arthritis	[No] _____	[Yes] _____
Cancer	[No] _____	[Yes] _____

**List of Medications:** *List name of medication, how often you take it and dosage:* \_\_\_\_\_

Have you **EVER** used **TAMSULOSIN** or **FLOMAX**? [No] \_\_\_\_\_ [Yes] \_\_\_\_\_

**List of Medication Allergies** (examples: Penicillin, Sulfa): \_\_\_\_\_

Do you have problems with anesthesia? [No] \_\_\_\_\_ [Yes] \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Do you drive? [No] \_\_\_\_\_ [Yes] \_\_\_\_\_

Do you drive at night? [No] \_\_\_\_\_ [Yes] \_\_\_\_\_

Do you drink alcohol? [No] \_\_\_\_\_ [Yes] \_\_\_\_\_ How much? \_\_\_\_\_

Do you smoke? [No] \_\_\_\_\_ [Yes] \_\_\_\_\_ How much? \_\_\_\_\_

**Patient Signature** X \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor Signature** X \_\_\_\_\_ **Date:** \_\_\_\_\_

# ADVANCED VISION CARE

Nicole Fram, MD Sahar Bedrood, MD, PhD, Tiffany Shahrooz, MD  
Juliana Nghiem OD, Soseh Markarian OD

**Permission to discuss medical care:** I hereby give Advanced Vision Care (AVC) permission to discuss and answer any questions regarding my medical care/condition to (must include translators):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # \_\_\_\_\_

**Assignment of Benefits & Confidentiality:**

**Assignment of Insurance benefits:** I hereby authorize direct payments to Advanced Vision Care (AVC) for services rendered under their supervision. I understand that I am financially responsible for any balance unpaid or not covered by my insurance.

**Authorization to release information:** I hereby authorize AVC to release any medical or incidental information that may be required for either medical care or in processing application for financial benefit.

**Medicare:** I certify that the information given by me is correct. I authorize release of all medical records on request. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as the original.

**Protected Health Information:**

Advanced Vision Care Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You also have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that:

- My protected health information may be disclosed or used for treatment, payment or health care operations.
- I have the right to review AVC's "Notice of Privacy Practices".
- AVC has the right to change their policies.
- I have the right to restrict the use of my information but AVC does not have to agree to those restrictions.
- I may revoke this consent in writing at any time and all future disclosures will then cease. AVC may condition treatment upon the execution of this consent.

\_\_\_\_\_  
Signature of Patient or representative

Date: \_\_\_\_\_

\_\_\_\_\_  
Relationship, if other than patient

**OFFICE POLICIES**

With my consent, Dr. Fram/Dr. Bedrood/Dr. Shahrooz/Dr. Nghiem/Dr. Markarian may use and disclose protected health information about me for treatment, payment, and healthcare operations. Dr. Fram /Dr. Bedrood/Dr. Shahrooz/Dr. Nghiem/Dr. Markarian or their designated staff and associates may contact me or leave messages at any of the addresses, fax or phone numbers that I have provided. I understand that I may be contacted by mail or telephone regarding my appointments, my test results and other matters related to my healthcare. I further understand that if I arrive more than 40 minutes late for my appointment, I might be asked to re-schedule. Dr. Fram/ Dr. Bedrood/ Dr. Nghiem/Dr. Markarian Notice of Privacy Practices outlines a more complete description of such uses and disclosures.

### **INSURANCE BENEFITS**

I understand that I am responsible, prior to treatment, for inquiring with my insurance company as to the benefits of my policy for services to be provided by Dr. Fram/Dr. Bedrood/Dr. Shahrooz/ Dr. Nghiem/ Dr. Markarian.

**REFRACTIONS are NOT covered by insurance and is a \$75.00 charge**

### **BILLING**

Insurance billing and collection related efforts are done in office. Please direct billing questions to 310-229-1220.

### **RELEASE OF MEDICAL INFORMATION**

I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of my medical information for the purpose of the Treatment, Health Insurance Matters (Medical Records Copies), and Healthcare Operations, by any means of communication, to Dr. Fram/Dr. Bedrood/Dr. Shahrooz/Dr. Nghiem/Dr. Markarian

### **PATIENT MEDICAL HISTORY**

**I have filled my patient medical history and clipboard to the best of my knowledge.**

### **MEDICATION RENEWAL**

I understand that my medication renewal is subject to a periodic review of my health status to assess indications, side effects and to monitor therapy.

### **OPEN PAYMENTS DATABASE**

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>.

I hereby consent to examination and treatment by Dr. Fram/Dr. Bedrood/Dr. Shahrooz/Dr. Nghiem/Dr. Markarian and authorize my insurance benefits to pay directly to Advanced Vision Care, Dr. Fram/Dr. Bedrood/Dr. Shahrooz/Dr. Nghiem/ Dr. Markarian.

I agree to be fully responsible for all charges for non-covered services, including measurements for eyeglasses. (REFRACTIONS)

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_