☐ **LANCASTER**
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1280 S. Victoria Ave. Suite 160 Ventura, CA 93003
Tel (805) 658-3937 Fax (805) 658-3930
WWW.ANACAPAVISION.COM

Babak Shabatian, M.D. · Phoenix Tran, O.D. · Ranjeet Bajwa, O.D. · Keely Toma, O.D.

***Today's Date*_____**

Patient Information

Name:_____ Age: _____ Date of Birth: _____
LAST FIRST MIDDLE

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ Cellular Phone_____ _____

SS#_____Driver's License No:_____State_____

Employer: _____Occupation_____

Work Phone: _____

Employer's Address_____ City_____State_____Zip_____

Financially Responsible Party: _____ Relationship to Patient: _____

Patient's E-mail address:_____@_____

Insurance Information

Primary Insurance Co.: _____ Policy #_____

Subscriber's Name_____ D.O.B_____Subscriber's SS# _____

Secondary Insurance Co.: _____ Policy #: _____

Subscriber's Name: _____ D.O.B_____Subscriber's SS# _____

Emergency Information

Person to contact in case of emergency: _____ Relationship: _____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____Cellular Phone_____

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Please take a moment to read the following financial policy information:

Missed Appointments: We have reserved a special time for your eye examination. In the event that you are not able to keep a scheduled appointment, we ask that you notify our office at **least 24 hours in advance**. Missed appointments not only delay your necessary treatment, but prevent us from accommodating others who need care. For this reason, a fee of $25 will be billed for missed appointments without adequate notice.

_____

Patient's Signature Date

Refraction: A refraction is a diagnostic test that is performed to determine a patient's best vision. It is a necessary test used for prescribing glasses as well as helping to determine if there is a medical problem with the eye preventing 20/20 vision. It is also required by most insurance plans prior to eye surgery. Most insurance carriers do not cover this portion of the examination. **Medicare requires us to bill the fee for this service to our Medicare patients.**

If a refraction is performed during your exam, there is a $50 fee, collected at the time of the visit. We will be happy to bill your insurance if your policy covers a refraction. If you would like to be billed for this service, the fee is $65 to cover our billing and mailing costs.

Forms: DMV, employer, insurance, or other special forms will be happily filled out for you by Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., These forms are completed after-hours, and will be mailed to you. There is a $20 charge for completion of forms.

Consent: I consent to necessary medical care and treatment by Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., I authorize release of any medical information necessary to process all claims and request all payments to be made Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I authorize Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., to bill my insurance and receive payment for the duration of my care. I understand that if I am determined not to be eligible for the health care or vision care provided, I agree to pay all charges in full within thirty (30) days of receiving notification. I have read all the information on this sheet. I certify that the information I have provided is true and complete to the best of my knowledge. I will notify you of any changes in the information above or any changes in my health status.

Patient or financially responsible party signature Date

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NEW PATIENT MEDICAL HISTORY

Patient name: _____ Sex: _____ Age: _____ Date of Birth: _____

Primary Care Physician: _____ Optometrist: _____

Who referred you to this office? _____

PREVIOUS EYE EXAMS AND GLASSES

What do you wear for vision correction? ☐ Glasses ☐ Reading Glasses ☐ Contact Lenses ☐ Nothing

Have you had vision correction surgery? ☐No☐RK ☐PRK ☐LASIK ☐Other _____

Who performed your last eye exam? _____ When? _____

When was your glasses or contact prescription last changed? _____

MEDICAL EYE HISTORY

Please place an "X" next to any of the following eye problems you are currently having:

_ blurred vision	____ headaches	____ excessive tearing	____crossed eyes
_ distorted vision	____ itching	____ bump on eyelid	____ wandering eyes
_ difficulty reading	____ redness	____ droopy eyelids	____ squinting
_ holding things too close	____ pain	____ puffy eyelids	____ double vision
_ holding things too far	____discharge	____ floaters	____ light sensitivity
_ eye discomfort	____ scratchy	____flashing lights	____ other (list below)

_____

Please indicate with an "X" whether or not you have ever had any of the following eye conditions:

___ cataract	____ retinal detachment	____ lazy eye (amblyopia)
___ glaucoma	____ macular degeneration	____ crossed eyes (strabismus)
___ corneal disease	____ eyelid problem	____ other (please list) _____

Have you ever had any eye surgery? ☐No. If yes, please list type, which eye, and approximate date.

_____ _____
type eye date type eye date

FAMILY EYE HISTORY

Do you have a family history of any of the following? ☐ No. If yes, indicate which relative(s)

	Relationship		Relationship		Relationship
___ cataract	_____	____ retinal detachment	_____	___ lazy eye (amblyopia)	_____
___ glaucoma	_____	____ macular degeneration	_____	___ crossed eyes (strabismus)	_____
___ corneal disease	_____	____ eyelid problem	_____	___ other (please list)	_____

EYE MEDICATIONS

Please list all prescription and non-prescription eye medications you are currently using, which eye, and how often.

Name	which eye	how often	name	which eye	how often

Name	which eye	how often	name	which eye	how often

ALLERGIES

☐ None. If yes, please list: _____

GENERAL MEDICAL HISTORY

Please list all non-eye medications you are taking (e.g. heart medications, blood pressure medications, aspirin, vitamins)

name	how often	name	how often	name	how often

name	how often	name	how often	name	how often

Please list all surgeries you have had and the approximate year they were done.

name	date	name	date	name	date

name	date	name	date	name	date

Have you ever had a bleeding problem? ☐No. If yes, please describe: _____

Have you or a blood relative ever had a problem with anesthesia? ☐ No. If yes, please describe: _____

_____

Please indicate with an "X" whether or not you personally have ever had any of the following medical conditions:

____ diabetes	____ stroke	____ cancer	____ AIDS or HIV
____ high blood pressure	____ kidney disease	____ hepatitis	____ poor hearing
____ heart disease	____ liver disease	____ arthritis	____ headaches
____ asthma or emphysema	____ thyroid disease	____ tuberculosis	____ autoimmune disease
____ extreme weight change			

Tobacco use: ☐No. If yes, number of packs per day: _____

Alcohol use: ☐ Never ☐ Occasional☐Weekly☐Daily

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? ☐ No. If yes, indicate which relative(s)

____ diabetes	____ stroke	____ cancer	____ AIDS or HIV
____ high blood pressure	____ kidney disease	____ hepatitis	____ poor hearing
____ heart disease	____ liver disease	____ arthritis	____ headaches
____ asthma or emphysema	____ thyroid disease	____ tuberculosis	____ autoimmune disease
____ extreme weight change			

Relationship to patient: _____

Signature of person completing form _____ Date _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date of Request_____

Patient's Name (please print)

Address

City State Zip Code

Date of Birth Social Security Number

I hereby request that my medical records be released to:

□ **TO** □ **FROM**

Babak Shabatian, M.D.
Ranjeet Bajwa, O.D.
Phoenix Tran, O.D.
Keely Toma, O.D.

□ **TO**□ **FROM**

Physician/ Optometrist's Name

Address

Telephone/Fax

I also give my permission to Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., to send a summary of his/her findings and treatment plan regarding my eye examination to my primary care physician and referring eye care specialist for continuity of care. I acknowledge that this permission can be limited or cancelled at any time at my request.

Signature of Patient Date

Signature of Person Acting on Behalf of Patient Date

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., *use and disclose protected health information (PHI) about me in order to carry out treatment, payment, and healthcare operations (TPO).*

Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., *office may call my home or other locations and/or persons _____ and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.*

I give my consent for Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., *office to mail, or e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.*

I understand that Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., *reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained in the front desk.*

I have the right to request that Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., *restrict how he/she uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound in this agreement.*

By signing this form, I hereby consent to Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., *use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it,* Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., *may decline to provide treatment to me.*

I acknowledge that I have read (or had the opportunity to read) the Privacy Notice.

_____
Signature of Patient or Legal Guardian

_____
Print Name of Patient

_____
Print Name of Legal Guardian, if applicable

_____
Date