Welcome

Thank you for selecting our healthcare team! We will strive to provide you with the best possible care. To help us meet all you healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

☐ Male ☐ Female

Patient # _____

Soc. Sec. # _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthday _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emegency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthday _____ Financial Institution _____

Employer _____ Work Phone _____ SSN # _____

Is this Person Currently a Patient our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I agree to be responsible for payment of all services. I understand that my insurance carrier may insurance carrier may pay less than actual bill for services.

X _____ _____

Signature of patient or parent if minor — Date

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

Please answer the following questions about your medical history:

1. Have you been under the care of a medical doctor during the past 2 years? ❑ YES ❑ NO
   Physicians Name _____
   Address _____
   City_____ State_____ Zip _____ Telephone ( )_____
2. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)? _____
   ❑ YES ❑ NO If YES, please explain: _____
   _____
3. Have you ever had any eye disease, eye surgery or eye lasers (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   ❑ YES ❑ NO If YES, please explain: _____
   _____
4. Do you take any medications? ❑ YES ❑ NO If YES, please explain: _____
   _____
5. Do you have any drug allergies? ❑ YES ❑ NO If YES, please list: _____
6. Have you had any of the following problems:

	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	❑	❑	_____
Ear/nose/throat problems(e.g., hearing loss,sinus problems,fever blisters)	❑	❑	_____
Heart problems(e.g., chest pain, irregular heartbeat)	❑	❑	_____
Respiratory problems(e.g., shortness of breath, wheezing, asthma, bronchitis)	❑	❑	_____
Gastrointestinal problems(e.g., heartburn, abdominal pain, diarrhea)	❑	❑	_____
Urinary problems (e.g., pain or discomfort, bladder infections)	❑	❑	_____
Skin Disease (e.g., rashes, eczema, dermatitis)	❑	❑	_____
Muskoskeletal problems(e.g., muscle aches, arthritis, swollen joints)	❑	❑	_____
Neurologic problems(e,g., numbness, weakness, paralysis, headache)	❑	❑	_____
Psychiatric problems(e.g., depression, anxiety)	❑	❑	_____

7. Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? ❑ YES ❑ NO If YES, please explain: _____
   _____
8. Do you: ❑ Smoke? if yes, how much?_____ ❑ Drink alcohol? If yes, how much? _____
   ❑ Drive ❑ Wear glasses ❑ Wear contact lenses
9. Women are you pregnant? ❑ YES _____ months ❑ NO
   ❑ Reviewed by physician Comments: _____
   _____

Physician signature _____ Date _____

CONSENT FOR TREATMENT

I understand the above information is necessary to provide me with care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.
I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Lastly, I agree to bn responsible for payment for all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand I will incur monthly late charges and the possibility of being sent to collections with additional charges.

Patient _____ Date _____ Witness _____

Parent or Responsible party_____ Relationship to Patient _____

Laser vision CORRECTION

ROBERT A. INNOCENZI, D.O., INC.
Eye Physician & Surgeon • Board Certified Ophthalmologist
USC Doheny Laser Eye Centers

EYE EXAMS WITH DILATION

Complete eye exam consist of a dilation drop in both eyes permitting the doctor to examine the back of the eye for a complete exam.

You will be light sensitive/sun light sensitive and blurry for the next four to six hours. This may affect your driving ability.

Signature_____ Date_____

13521 Sherman Way, Suite I
Van Nuys, CA 91405
(818) 988-4450
Fax (909) 988-4485

ROBERT INNOCENZI, D.O
13197 CENTRAL AVE.
SUITE 101
CHINO, CA 91710
(909) 590-2073

13867 Foothill Blvd., Suite 108
Sylmar, CA 91342
(818) 362-5888
Fax (818) 364-8566

Laser Vision CORRECTION

ROBERT A. INNOCENZI, D.O., INC.
Eye Physician & Surgeon • Board Certified Ophthalmologist
USC Doheny Laser Eye Centers

Acknowledgement of the Use and Disclosure of your Health Information
For Treatment, Payment and/or Healthcare Operations

I understand as part of my health care, Dr. Robert A. Innocenzi maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any future care or treatment. This information serves as the following:

- The means of planning my care and treatment
- Communication among the health professions that contribute to my care
- Information for applying my diagnosis and treatment to obtain payment for service rendered.
- Third party payers can verify that services billed were actually provided

I have been provided with a **Notice of Privacy Practices** that gives a more complete description of the information, uses and disclosures.

I understand that Dr. Robert A. Innocenzi reserves the right to change his notice and practices prior to implementation, with accordance to section 164.520 of the Code of Federal Regulations. If Dr. Innocenzi changes his notice, I may obtain a revised copy by contacting his compliant officer.

I understand that as a part of this office's treatment, health care, payments, it may become necessary to disclose my health information to another entity and I consent such disclosure for these uses, including disclosures via facsimile.

I understand the information listed above and consent to such information being disclosed for these uses including sending information via facsimile.

_____ _____
Patient's or Representative's Signature Date

_____
Relationship to Patient

A copy of the full Not ce of Patient Privacy Act is available upon request.

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(909) 590-2073