INNOCENZI
EYE ASSOCIATES

Thank you for selecting our healthcare team! We will strive to provide you with the best possible care. To help us meet all your healthcare needs, please fill out this form.

(Please print)

PATIENT INFORMATION (confidential)

Name_____ **Date of Birth** _____ **Male**____ **Female** ____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (_____)_____ **Cell Phone** (_____)_____

Employer _____ **Work Phone** (_____) _____

EMAIL_____ **SSN:** _____

IN CASE OF EMERGENCY:

Name _____ **Phone #** (_____) _____

PHARMACY:

Name: _____ **City:** _____ **Phone #**_____

RESPONSIBLE PARTY (if other than patient):

Name_____ **Social Security #** _____

Address_____ **Date of Birth** _____

INSURANCE INFORMATION:

(1) PRIMARY Insurance Company: _____ **Group /Policy #** _____

Name of policy holder _____ **Member ID#** _____

Birth date _____ **Patient Relationship to Policy Holder:** _____

(2) SECONDARY Insurance Company: _____ **Group /Policy #** _____

Name of policy holder _____ **Member ID#** _____

Birth date _____ **Patient Relationship to Policy Holder:** _____

WHOM MAY WE THANK FOR REFERRING YOU?

☐ **Internet** ☐ **Friend / Patient** _____ ☐ **Other (specify)** _____

☐ **Physician / Optometrist** _____

Name **Address** **Phone #**

INNOCENZI
EYE ASSOCIATES

MEDICAL HISTORY

Primary Care Physician:		
Address:	**City:**	**Zip:**
Phone# ( )	**Fax # ( )**	

Please list medications you are currently taking, including eye drops:			
1.		5.	
2.		6.	
3.		7.	
4.		8.	

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?			
	YES	**NO**	**If yes, please explain:**
Do you have any allergies to medication?			
Allergic / Immunologic: (hay fever, allergies)			
Blood/Lymph: (blood disorders, leukemia)			
Cardiovascular: (stroke, heart problems, chest pain, irregular heartbeat, high BP)			
Ear/nose/mouth/throat: (hearing loss, sinus problems, sore throat)			
Endocrine: (Thyroid, Diabetes)			
Eyes: (Glaucoma, Cataract, Macular Degeneration, retinal problems, other, please specify)			
Gastrointestinal: (heartburn, abdominal pain, diarrhea, vomiting)			
Genital/kidney/bladder: (urinary problems, blood in urine)			
Musculoskeletal: (muscle aches, joint pain, swollen joints)			
Neurological: (numbness, weakness, headaches, paralysis)			
Psychiatric: (depression, anxiety)			
Respiratory: (asthma, shortness of breath, wheezing, coughing)			
Skin: (skin rashes, excessive dryness, cancer)			
FAMILY & SOCIAL HISTORY			
Do any eye diseases run in your family?	**YES**	**NO**	**If yes, please explain:**
Glaucoma:			
Macular Degeneration:			
Retinitis Pigmentosa:			
OTHER:			
Do you smoke: *If yes, how much?*			
Drink alcohol? *If yes, how much?*			
Flu shot (influenza vaccine) *If yes, when?*			
Pneumococcal vaccine (pneumonia)			

Patient Signature **Date**

Physician Signature **Date**

Informed Consent or Refusal for Dilated Fundus Exam

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes to better check the health of the inside of the eyes.

The pupils are simply and entry way/opening to the inside of the eye. Looking through an *undilated* pupil is similar to looking into a room through a keyhole in the door; the doctor may see only about 20% to 50% of what is inside. However, looking through a *dilated* pupil is like looking into a room through an open door; the doctor gets a complete view of the inside of the eye.

A dilated fundus exam is recommended routinely at the time of your initial exam for baseline recording and usually every other full eye exam thereafter (about every 2 to 3 years). It should be done annually if you have any of the conditions listed under **Benefits** below.

Benefits

Dilation allows the doctor a better view of the peripheral retina for disease. It is highly recommended if you or your family has a history of high blood pressure, diabetes, past retinal problems (i.e., retinal detachment/tears), or extreme nearsightedness. It is also recommended if you have experienced sudden cloudiness of vision, especially in one eye, "curtain or veil-like "obstruction of vision, a sudden onset of many "floaters" or flashing lights off to the side of your vision.

Risks

- Some blurring of vision and glare because of enlarged pupils for about 2 (but up to 6) hours. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision.
- Difficulty with near reading for 1 to 2 hours. The focusing ability is impaired and may cause a slight headache if you try to read.
- Induced ocular hypertension. Rare cases have been reported in which redness and sharp pain are experienced because of increased eye pressure. If this happens, contact the doctor immediately.

Check one :

____ I understand the above and **APPROVE** to have the dilation done.

____ I understand the above and **DECLINE** dilation at this time. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

Patient's Signature: _____ **Date:** _____

Witness (*office staff*): _____ **Date:** _____

vision specialist

ROBERT A. INNOCENZI JR., D.O., INC.

Eye Physician & Surgeon • Board Certified Ophthalmologist

FINANCIAL AGREEMENT

I understand that I am an eligible member with my health plan and I have selected **Dr. Robert A. Innocenzi** as my provider for myself or my dependent.

FINANCIAL RESPONSIBILITY: You are responsible for all charges associated with your visit for yourself or dependent. We will bill your insurance company upon providing us with all requested information.

Your signature on this form acknowledges that you agree to bear full financial responsibility for **any deductibles, co-payment, co-insurance and non-covered services.** Non-covered services including/but not limited to the following:

* Services for which you were not eligible on that date of service.
* Services which are not a covered benefit under your Health Plan.
* Services which have not been approved for payment by your Health Plan.

PATIENT BILLING: Patients who have outstanding balances are billed monthly. All balances are due within 30 days from the billing date. All outstanding balances must be paid prior to any future services being rendered.

_____

Patient Name (please print)

_____

Signature of Responsible Party

_____

Date

13197 Central Ave., Suite 101 • Chino, CA 91710 • (909) 590-2073 • Fax (909) 590-2457

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 Notice of Patient Privacy Act is available upon request.

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