MISSION VALLEY EYE MEDICAL CENTER

SARB HUNDAL, M.D., F.A.C.S.
SURGEON/DIRECTOR

39263 MISSION BLVD., • FREMONT, CA 94539 • (510) 796-4500 • FAX (510) 796-4573

Home Phone #_______ - _______ - _________ Cell Phone # _____-______________________

Patient's Last Name:________________ First:________________________ Middle Initial: _______________

SS #___ -_____ - _____ Date of Birth ___ /____/____ □ Male or □ Female Status: □ S □M D □ W □

Home Address:____ Apartment Number:_____________________

City:__________________________ State_________Zip Code:______Email address:_________________

Preferred Method of Contact: E-mail □ Phone □ Mail □

Occupation: _________________________ Employer Name:____

Employer Address:________________ City:__________ State:________ Zip Code:___________________

Work Phone #______ -_______ -____ Emergency Phone #_____ -_______ -______________________

Relationship to Patient:__________________________ Name ____

Referred By:_________________________________ Primary Care Physician:_______________________

How did you hear about us? ___Advertisement ___Employer ___ Friend/Relative _____ Other: ______________

Race: Please mark what best describes you. If more than one, please mark numerically in order.

□ White/Caucasian □ American Indian/Alaska Native □ Black/African American
□ Asian: □ Native Hawaiian/Other Pacific Islander Hispanic/Latino Yes □ No □
□ Other: Ethnicity: ___________ □ Decline

Preferred Pharmacy____

PRIMARY INSURANCE: Subscriber to Insurance: □ Self □ Spouse □ Parent □ Company

Last Name:________________________________ First: Middle: _____________________________________

SS #____- ______-_____ Date of Birth:___________ Insurance Name:______________________________

Subscriber ID:___________________ Group #__________

SECONDARY INSURANCE: Subscriber to Insurance: □ Self □ Spouse □ Parent □ Company

Last Name:_________________________________ First: Middle: _____________________________________

SS #_____-_____-____ Date of Birth:____________ Insurance Name:_________________________________

Subscriber ID:________________Group # ________________

Date: _______________________ Signature ____

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CONSENT FOR DILATING THE EYES

I understand that the dilating drops that the doctor and his staff are going to use in my eyes for comprehensive exam today, can cause blurry vision and can interfere and effect my vision for driving and other work for a few hours.

I also understand that if I refuse to get my eyes dilated, the doctor may not be able to do a complete and detailed exam.

I also understand that my vision (after the dilating drops) may interfere with my doing any tasks including driving. I take responsibility not to do such tasks until my vision is back to normal.

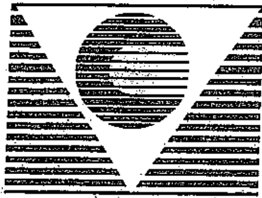
Mission Valley Eye Medical Center does provide dark spectacles for patients after dilation is done

PLEASE NOTE:

1. Co-Pay is expected at time of the service.
2. It is important to keep accurate records. **PLEASE** let us know of any changes. (address, insurance, phone)
3. If the doctor does refraction, there will be a $45 charge, payable at the time of the service, if not covered by insurance.
4. If you can't make your appointment please call 24 hours in advance. No Show or cancellation of the same day can results in $25 fee.

The undersigned have insurance coverage with ___________ and assign directly to Mission Eye Medical Center and/or medical benefits, if any, otherwise payable to the group for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all insurance information necessary to secure the payment of benefits.

Patient Signature______________________ Witness Signature ______________________



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Name: ______________________ Date of Birth: ____________________

Referring Doctor: ________________

Do you wear glasses ☐ Yes ☐ No

Reason for today`s Visit :______________________________________

Are you currently experiancing any of the following (please make all that apply)

	Abnormal Head Position		Dry Eyes		Flashes of light/ Floters		Itchy Eyes/ Lids
	Blurry/ Decreased Vision		Eye Injury		Glare/ Light Sensitivity		Red Eye (s)
	Double Vision		Eye Pain		Growth/Bump in Lid		Watery Eyes
	Droopy Lid		Eye Misalignment		Headaches		other_______

Past Ocular History (Please mark all that apply)

	NONE		Cataract(s)		Hyperopia		Myopia
	Amblyopia (Lazy eye)		Diabetic Retinopathy		Iritis		Optic Neuritis
	Aphakia		Dry Eyes		Keratoconus		Retinal Detachment
	Astigmatism		Glaucoma		Macular Degeneration		Other__________

Ocular Significant Illnesses/Conditions (please mark all that apply)

	NONE		Diabetes		Hypertention		Parkinson`s Disease
	Bell`s Palsy		Headache/Migranes		Hyperthyroidism		Rheumatoid Arthritis
	Bleeding Disorder		Hepatitis A B C		Lupus		Sjogren`s Syndrome
	Brain Tumor		Herpes Simplex		Meningitis		Stroke/ TIA
	Cancer		Histoplasmosis		Myasthenia Gravis		Syphilis
	Chicken pox/Shingles		HIV/ AIDS		Multiple Sclerosis		Other:__________

Other Past Medical Illnesses/ Surgical Procedures (Please mark all that apply)

	NONE		Depression		Irregular Heart Beat		Polymalgia
	Anemia		Eczema		Kidney Disease		Psychiatric Disorder
	Asthma		Hearing loss		Lung Disease		Seizures
	CHF		Heart Attack		MRSA		Skin Cancer
	COPD/ Emphysema		Hypothyroidism		Osteoarthritis		Other:__________

Family History (please mak all that apply)

	Blindness		Eye Misalignment		Hyperthyroidisim		Retinal Detachment
	Cancer		Glaucoma		Lazy Eye		Strabismus
	Cataracts		Heart Disease		Macular Degeneration		Stroke
	Diabetes		High Blood Pressure		Migrains		Other__________

Allergies

	Latex		Other ____________				
	Penicillin		____________				

Systemic Medications (please list over the counter / Supplements/)

____

____

____

Ocular Medication: (please list all eye medication including strenghts/ dose)

____

____

General Surgeries (please include date)

____

____

Social History:

Do you Smoke Y N ________ Packs/Day Have you ever smoked? Y N

Do you drink alcohol Y N ________ glasses / bottles per day/week

Do you use drugs ? Y N Substance :______________ Frequency : Daily Weekly Occasionally

Review of Systems

Eyes * — Normal

Previous Surgery	YES	NO
Contact Lens	YES	NO
Pain	YES	NO
Double Vision	YES	NO
Glaucoma	YES	NO
Cataracts	YES	NO
Macular Degeneration	YES	NO
Dry Eyes	YES	NO
Blurry Vision	YES	NO
Eye pain/burning	YES	NO
Flashes of Light/Floaters	YES	NO
Glare/Light Sensitivity	YES	NO

Ear, Nose, and Throat * — Normal

Hard of Hearing	YES	NO
Ringing in Ears	YES	NO
Vertigo	YES	NO
Cold Sores	YES	NO
Dry Mouth	YES	NO

Cardiovascular * — Normal

Chest Pain	YES	NO
Dizziness	YES	NO
Fainting Spells	YES	NO
Shortness of Breath	YES	NO
Irregular Heart Beat	YES	NO
Difficulty Lying Flat	YES	NO
Leg Swelling	YES	NO
Palpitations	YES	NO

Constitutional * — Normal

Fatigue/Weakness	YES	NO
Fever	YES	NO
Weight Gain/Loss	YES	NO

Respiratory * — Normal

Cough	YES	NO
Congestion	YES	NO
Wheezing	YES	NO
Asthma	YES	NO
Shortness of Breath	YES	NO

Gastrointestinal * — Normal

Heartburn	YES	NO
Nausea/Vomiting	YES	NO
Jaundice/Hepatitis	YES	NO
Abdominal Pain	YES	NO
Diarrhea	YES	NO

Genito-Urinary * — Normal

Pain/Difficulty	YES	NO
Blood in Urine	YES	NO
History of Kidney Stones	YES	NO
History of STD's	YES	NO
Discharge	YES	NO
Urinary Incontinence	YES	NO

Psychiatric * — Normal

Anxiety/Depression	YES	NO
Mood Swings	YES	NO
Difficulty Sleeping	YES	NO

Endocrine * — Normal

Increased Thirst	YES	NO
Increased Hunger	YES	NO
Increased Urination	YES	NO
Increased Sweating	YES	NO
Fingernail Changes	YES	NO

Blood/Lymphnodes * — Normal

Easy Bruising	YES	NO
Gums Bleed Easily	YES	NO
Prolonged Bleeding	YES	NO
Heavy Asprin Use	YES	NO
Blood Clots	YES	NO
Swollen Glands	YES	NO

MusculoSkeletal * — Normal

Stiffness	YES	NO
Arthritis	YES	NO
Joint Pain/Swelling	YES	NO
Back Pain	YES	NO
Weakness	YES	NO

Skin * — Normal

Rash/Sores	YES	NO
Lesions	YES	NO
Hives/Eczema	YES	NO
Cafe-au-lait Spots	YES	NO

Neurological * — Normal

Seizures	YES	NO
Weakness/Paralysis	YES	NO
Numbness	YES	NO
Tremors	YES	NO

Immunologic * — Normal

Hives	YES	NO
Itching	YES	NO
Runny Nose	YES	NO
Sinus Pressure	YES	NO