



LA PALMA EYE CARE CENTER
Serving our community for 26 years

Today's Date: _____ / _____ / _____

First Name: _____ MI.: _____ Home Phone: () -

Last Name: _____ Work Phone: () -

Birth Date: _____ / _____ / _____ Cell Phone: () -

Marital Status: Married Single *Sex:* M F SS#: _____

Address: _____ City: _____ CA Zip: _____

Responsible Party: Self Other _____

Relationship: _____ Phone: () -

Address: _____ City: _____ CA Zip: _____

Primary Insurance: _____ Medicare

Subscriber Name Self Other _____

Secondary Insurance: _____ Medicare Medi-Cal

Subscriber Name Self Other _____

Emergency contact: Name: _____ Phone: () -

Name of family physician: _____

I authorize payment of medical benefits and release of medical information to Ilan Hartstein, M.D. inc. I agree to pay any amount approved but not paid for by my insurance eg: Co-pay, Co-insurance, non covered services, I acknowledge that I have received a copy of the notice of Privacy Practice.

Patient's or Authorized Person's Signature

_____/_____/_____
Date



COMPREHENSIVE HISTORY (Please fill in all sections)

Name: _____

Previous eye history: None

Date: _____ Sex: ___ Age: _____

Referred by _____
 Doctor Friend Family Member

Previous medical history: None

Chief complaint/Reason for visit: _____

Allergies to medications: No Yes
If yes please list allergies: _____

Current medications or drops: None

MEDICAL HISTORY/SYSTEM REVIEW

Do You Have/ Have you Had?	Yes	No	Comments
Asthma			
Shortness of Breath			
Chest Pain			
Heart Attack			
High Blood Pressure			
Stroke			
Hepatitis			
Ulcer			
Cancer			
Kidney Stones			
Headaches			
Diabetes (How long?)			
Thyroid Trouble			

Continued	Yes	No	Comments
Arthritis			
Skin Problems			
Hearing Problems			
Tobacco (Packs/day)			
Alcohol			

Other: _____

Family History

- Glaucoma
- Retinal Disease
- Blindness
- Diabetes
- None

Signature: _____

Date: _____