New Patient Information

Today's Date:_____/_____/_____

Name: _____ Date of Birth:_____

Address:_____City:_____

State: _____ Zip Code:_____ Home Phone #:_____

Cell Phone #:_____ Email: _____

Date of last exam: _____ How did you hear about us?:_____

Occupation: _____ Business Phone #:_____

Which phone number do you preferred to be contacted on? Home_____ Cell_____ Work_____

Please list names of any Adults in your household:_____

Patient Questionnaire

Are you having any trouble seeing with: Near vision_____ Distance Vision_____ Intermediate/Computer Vision _____

Do you experience any eye pain? Yes_____ No_____ How Often? Occasionally_____ Frequently_____ Always_____

Do your eyes sometimes: Burn_____ Ache_____ Itch_____ Water_____ Tire_____

Are you sensitive to light? Yes_____ No_____

Are you bothered by glare at night? Yes_____ No_____

Do you currently wear glasses? Yes_____ No_____ Are they for: Distance_____ Reading_____ Both_____ Computer_____

Do you work on a computer Yes_____ No_____ How long per day? 1-2 hrs_____3-4 hrs_____5-6 hrs_____ 8+ hrs_____

Are you currently wearing contact lenses? Yes_____ No_____ If so, How old is the current pair you are wearing?_____

Are you interested in finding out if you are a candidate for contacts? Yes_____ No_____ I already wear contacts_____

Do you wear your contacts every day? Yes_____ No_____ How often do you sleep in your contacts?_____

How often do you switch to a new pair of contacts?:

1-2 weeks_____ 3-4 weeks_____ 1-2 months_____ 3-6 months_____ 6-12 months_____ 1+ years_____

Are you interested in LASIK? Yes_____ No_____

Since doctor highly recommends yearly health checks, we suggest being pre-appointed for your exam next year. It is a tentative appointment set with the same doctor, around the same date and time. It can always be changed! We send you a notice in the mail to inform you of your appointment the month before it is scheduled with the day, date, and time.

Would you like to be pre-appointed for next year? Yes_____ No_____ It doesn't matter_____

Medical History

Medications currently taking:_____

Medical Allergies:_____

Have **YOU** or **ANYONE BLOOD RELATED** to you have or have had any of the following?

High Blood Pressure, who?_____ **Diabetes**, who?_____ **High Cholesterol**, who?_____

Cataracts, who?_____ **Glaucoma**, who?_____ **Macular Degeneration**, who?_____

_____ Signature of Party Responsible for patient

_____ Relationship to Patient

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Dieter Steimann, O.D.
Hans Steimann, O. D.
18282 Imperial Hwy.
Yorba Linda, CA 92886
(714) 777-3969

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care provider who may be involved in that treatment directly and indirectly
- Obtain payment from the third-party payers for health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my eye care provider's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such ***Notice of Privacy Practices***. I understand that my eye care provider has the right to change the ***Notice of Privacy Practices*** and that I may contact this office at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restriction.

Patient Name (Print):_____

Signature:_____

Date:_____

Dependent family members also covered by this acknowledgement:

_____

_____

INSURANCE DISCLAIMER

Today's Date:_____/_____/_____

Name of Vision Insurance_____

Name of Medical Insurance_____

Medical Insurance ID_____

Patient Name_____Relation to Insured_____

Primary Person Insured_____

Primary Insured Date of Birth_____/_____/_____

Primary Insured Social Security Number(for insurance purposes ONLY)_____

Yorba Linda Optometric Vision Center
Dr. Dieter Steimann, O.D.
Dr. Hans Steimann, O.D.
18282 Imperial Hwy.
Yorba Linda, CA 92886

Patient Financial Responsibility

I hereby authorize the above vision care provider to apply for benefits on my behalf for covered services rendered by them. I also assign my benefits and request that all payments from my vision care be made directly to the vision care provider. I agree to assume responsibility of full payment pending any remaining balance that is not covered by my provided vision care. All copayments and fees are due at the time of service.

I certify that the information I have reported with regard to my coverage is correct. I further authorize this vision care provider to release to my vision coverage carrier and its agents any information related to this or any related claim.

_____

Signature of responsible party & relationship
to patient