Patient Registration Form **Date:_____**

PATIENT INFORMATION

Patient's last name: First: Middle:					☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.
Marital status: S☐ M☐ W☐ D☐	Social Sec. No.: - -	Birth Date(MM/DD/YY):	Age:	Ethnicity:	Sex: ☐ M ☐ F
Street address:		City:	State:	Zip code:	
Home phone #:	Cell phone#:	Work phone #:			
Email Address:					
Occupation:	Employer name & address:				
Primary physician's name:		Primary physician's phone:		Primary physician's fax:	
Other doctor:					
Referring doctor's name:		Referring doctor's phone:		Referring doctor's fax:	
Guardian's name (if patient under 18) :		Relationship to patient:		Phone:	

INSURANCE INFORMATION

(please give insurance card to receptionist)

Are you covered by insurance: ☐ Yes ☐ No				
Indicate primary insurance ☐Medi-Cal ☐Medicare ☐ PPO ☐ HMO ☐ CCS ☐ Other:_____				
Subscriber's name:	Subscriber's Soc Sec #: - -	Birth date:	Group #:	Policy #:
Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:				
Name of secondary insurance:	Subscriber's Soc Sec #: - -		Group #:	Policy #:

IN CASE OF EMERGENCY

Name of local friend/relative:	Relationship to patient:	Phone #:

I hereby authorize Dr. Song, Dr. Birndorf, and Dr. Dolorico to furnish information to my insurance carrier concerning my illness and treatments.
I hereby assign Dr. Song, Dr. Birndorf, and Dr. Dolorico all payments for medical services rendered to me or my dependants.
I understand that I am responsible for any amount not covered by the insurance carrier.
I authorize Dr. Song, Dr. Birndorf, and Dr. Dolorico to use and disclose protected health information about me to carry out treatment, payment, and healthcare operations and have received the Notice of Privacy Practices.
I understand that drops may be put into my eyes that may temporarily blur my vision for up to 4-6 hours and have made appropriate arrangements for my transportation and other activities.
I agree that all disputes will be resolved via arbitration at the corporation's choosing.
I give consent for photos to be taken of me for medical purposes.
I understand there is a charge of $25 for appointments not cancelled within 48 hours and $150 for surgeries within 5 days.

_____ _____

Patient/Guardian Signature Date

Patient History Form

REVIEW OF SYSTEMS Do you currently have any of the following (please check):		
☐ **Diabetes** ☐ **Thyroid** ☐ **Other:** ☐ **Hypertension** ☐ **Gastrointestinal** ☐ **Asthma/pulmonary** ☐ **Skin** ☐ **Cardiac** ☐ **Kidney** ☐ **Stroke**		
Medications, including eye drops, vitamins	☐ Y ☐ N	**If yes, please fill in MEDICATION LIST**
Blood thinners (aspirin, ibuprofen, Plavix, Coumadin)	☐ Y ☐ N	
Do you have any allergies to medication?	☐ Y ☐ N	
Constitutional (fever, weight loss, other)	☐ Y ☐ N	
Eyes (glaucoma, cataract, retina, including surgeries and dates)	☐ Y ☐ N	
Ear/nose/mouth/throat (hearing loss, sinus problems, sore throat)	☐ Y ☐ N	
Cardiovascular (heart problems, chest pain, irregular heart beat)	☐ Y ☐ N	
Respiratory (asthma, shortness of breath, wheezing, coughing)	☐ Y ☐ N	
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	☐ Y ☐ N	
Genitourinary (urinary problems, blood in urine)	☐ Y ☐ N	
Integumentary (skin rashes, excessive dryness)	☐ Y ☐ N	
Musculoskeletal (muscle aches, joint pain, swollen joints)	☐ Y ☐ N	
Neurological (numbness, weakness, headaches, paralysis)	☐ Y ☐ N	
Hematologic/Lymphatic (blood disorders, leukemia)	☐ Y ☐ N	
Allergic/Immunologic (hay fever, allergies)	☐ Y ☐ N	
Endocrine (thyroid problems)	☐ Y ☐ N	
Psychiatric (depression, anxiety)	☐ Y ☐ N	

Do any medical or eye diseases run in your family?		
☐ **Glaucoma**	☐ Y ☐ N	**Do you smoke?** ☐ Y ☐ N
☐ **Diabetes**	☐ Y ☐ N	**If YES, how much?**
☐ **High blood pressure**	☐ Y ☐ N	
☐ **Macular degeneration**	☐ Y ☐ N	**Do you drink alcohol?** ☐ Y ☐ N
☐ **Other**_____		**If YES, how much**?

Patient's Signature:_____ Date:_____

Physician's Signature:_____ Date:_____

CURRENT MEDICATIONS		
Medication	Dosage	Reason

Patient Name: _____ Date of Birth: _____

Date: _____

Center for Oculofacial & Orbital Surgery

DRSONGVISION ophthalmology

Southern California Eye Physicians & Surgeons

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Oculofacial, Plastic, Orbital,
Reconstructive & Lacrimal Surgeon

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www.DrSongVision.com

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T: (626) 844-9393

eFax: (562) 427-2525

3771 Katella Ave., #209
Los Alamitos, CA 90720
T: (562) 427-0700
T: (562) 431-3771

FINANCIAL RESPONSIBILITY

NOTICE OF PRIVACY PRACTICE-ACKNOWLEDGEMENT

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, extent that you have taken action relying on the consent.

By signing below, I acknowledge receipt of the Notice of Privacy Practice.

Patient Name: _____

Signature: _____

Date: _____

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FINANCIAL RESPONSIBILITY

Date: _____

Eligibility and authorizations are not a guarantee of payment. You will receive services today with understanding that in the event your coverage is **NOT EFFECTIVE YOU WILL BE BILLED AND HELD FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED.**

I have read all of the above information and understand my possible financial responsibility for the services that will be rendered and hereby affix my signature as an acknowledgement of the above understanding.

Patient name (Print): _____

Signature: _____

Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient's Phone #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

The Fee for ALL Medical Records is $25.00 (payment is required upon request of release).
Please allow 7-14 days to process, if needed sooner please let us know.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.