David J. Fuerst, MD Inc.
Patient Registration Form

Patient Information

Patient Name:_____Social Security #:_____

Address: _____Email Address:_____

City:_____ State: _____ Zip Code: _____

Date of Birth: _____ Male: ☐ Female: ☐

Home Phone: _(___)_____ Work Phone: _(___)_____

Emergency contact:_____ Relation: _____Phone: _____

Additional Information

Primary Care Physician: _____ Phone:_____

How did you hear about Dr. Fuerst? Phone Book ☐ Friend ☐ Insurance Co. ☐

Referred by:_____ ☐ Other (please describe)_____

Pharmacy:_____

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at openpaymentsdata.cms.gov."

Authorization for Treatment and Release of Medical Records

I hereby authorize David Fuerst, MD and assistants to treat me. Also by signing below I am authorizing David Fuerst, MD to furnish the above insurance company (ies) all the necessary information that they may request. It is the policy of David Fuerst, MD Inc. to require payment at the time services are provided. In the event that patient is in a prepaid plan only the co-payment is applicable. By signing below I am stating that I understand this policy. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediate carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment below.

I hereby irrevocably assign to the doctor all payments for medical services rendered and ALL MAJOR MEDICAL BENEFITS, from my insurance company (ies) and Medicare.

X _____ ___/___/___ X_____ ___/___/___

Patient Signature Date Parent/Guardian Date

Name_____ Date_____

Date of **Birth**_____ Date of **last eye exam**_____
List any **medications** you currently take (Rx and over-the-counter): _____
_____
Do you have **allergies** to any medications? **YES NO**
If YES, list the medications:_____
List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):
_____
List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**

Have you ever had a blood transfusion? .....**YES NO**

Do you drink alcohol?.....**YES NO** If YES, how much? _____

Do you smoke?.....**YES NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____

Name: _____ **Date of Birth:** _____

Supplemental History
(These are categories mandated by the US government)

1. What is your preferred language? (circle one)

   ♦ English ♦ Spanish ♦ Chinese ♦ Other_____

2. Please circle your race:

   ♦ American Indian ♦ Alaska Native Asian ♦ Black / African American

   ♦ Native Hawaiian / Pacific Islander ♦ White ♦ Decline to answer

3. Please circle your ethnicity:

   ♦ Hispanic or Latino ♦ Not Hispanic or Latino ♦ Decline to answer

4. Please circle your smoking status below:

   ♦ Current – every day ♦ Current - some days ♦ Former smoker

   ♦ Never smoker ♦ Decline to answer

David J. Fuerst , MD Inc. Privacy Statement

David J Fuerst, Medical Group, Inc. This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a copy of this Notice upon request.

Patient Health Information Under Federal Law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and health related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose information without your permission.

Example of Treatment, Payment, and Health Care Options

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of the payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and other like it.

Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you.

Other Uses and Disclosures: We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect or similar injuries and events.

Research: We may use or disclose information approved for medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to the public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness. In any other situations, we will ask for your written authorization to disclose information. You can later revoke that authorization to stop any future uses or disclosures.

Individual Rights You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree we must abide by those restrictions.

Confidential Communication: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using a postcard to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. A fee may apply.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing or add the missing information.

Our Legal Duty We are required by law to protect and maintain privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding health information, and to abide by the terms of this Notice currently in effect.

Changes in Privacy Policies We may change our policies at any time. Before we make significant changes in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person If you have any questions, requests, or complaints, please contact:

David J. Fuerst M.D., Inc. Mary Trapp 1135 S. Sunset Ave Suite 312 West Covina, CA 91790

I, _____ hereby acknowledge receipt of the Notice of the Privacy Practice given to me.

David J. Fuerst, M.D.
Ophthalmology
Corneal and Refractive Surgery
Small Incision Cataract Surgery

Eye History

Name: _____ Date: _____

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? ☐ Yes ☐ No

2. Do you wear contact lenses? ☐ Yes ☐ No

3. Do you have problems reading? ☐ Yes ☐ No

4. Are you currently experiencing any eye symptoms? Please circle all that apply:

Light Sensitivity Blurred Vision Eyelid Crusting Flashes of Light Halos
Discharge Eye Pain Double Vision Decreased Vision Floaters

5. Have you ever had an eye injury? Please describe: _____ _____
_____

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:
_____R / L Date: _____
_____R / L Date: _____

7. Are you currently using any eye medications? Please list name and how often used:
_____ _____
_____ _____

8. Are you being treated for any medical conditions? Please circle all that apply:
Diabetes Heart Disease High Blood Pressure High Cholesterol
Stroke Arthritis Other: _____

9. What medications are you taking? Please list:
_____ _____
_____ _____
_____ _____

10. Are you allergic to any medication? Please list: _____

11. Do you have any family history of eye problems? Please list family relationship:
Glaucoma _____ Cataract _____
Retinal Disease _____ Macular Degeneration _____

12. Please circle any of the following that you would like more information about:
Cataract Surgery LASIK Contact Lenses
Diabetic Eye Disease Other:_____ Glaucoma