



LANCASTER

1739 West Avenue J. Lancaster, CA 93534
Tel. (661) 940-0555 Fax. (661) 940-0558
WWW.LANCASTEREYE.COM

TORRANCE

1900 Hawthorne Blvd. Suite 100. Torrance, CA 90503
Tel. (310) 909-8880 Fax. (310) 693-8091
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VENTURA

1280 S. Victoria Ave. Suite 160 Ventura, CA 93003
Tel (805) 658-3937 Fax (805) 658-3930
WWW.ANACAPAVISION.COM

Babak Shabatian, M.D. · Phoenix Tran, O.D. · Ranjeet Bajwa, O.D. · Keely Toma, O.D.

Today's Date _____

Patient Information

Name: _____ Age: _____ Date of Birth: _____
LAST FIRST MIDDLE

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cellular Phone _____

SS# _____ Driver's License No: _____ State _____

Employer: _____ Occupation _____

Work Phone: _____

Employer's Address _____ City _____ State _____ Zip _____

Financially Responsible Party: _____ Relationship to Patient: _____

Patient's E-mail address: _____ @ _____

Insurance Information

Primary Insurance Co.: _____ Policy # _____

Subscriber's Name _____ D.O.B _____ Subscriber's SS# _____

Secondary Insurance Co.: _____ Policy #: _____

Subscriber's Name: _____ D.O.B _____ Subscriber's SS# _____

Emergency Information

Person to contact in case of emergency: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Cellular Phone _____



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Please take a moment to read the following financial policy information:

Missed Appointments: We have reserved a special time for your eye examination. In the event that you are not able to keep a scheduled appointment, we ask that you notify our office at least 24 hours in advance. Missed appointments not only delay your necessary treatment, but prevent us from accommodating others who need care. For this reason, a fee of \$25 will be billed for missed appointments without adequate notice.

Patient's Signature

Date

Refraction: A refraction is a diagnostic test that is performed to determine a patient's best vision. It is a necessary test used for prescribing glasses as well as helping to determine if there is a medical problem with the eye preventing 20/20 vision. It is also required by most insurance plans prior to eye surgery. Most insurance carriers do not cover this portion of the examination. **Medicare requires us to bill the fee for this service to our Medicare patients.**

If a refraction is performed during your exam, there is a \$50 fee, collected at the time of the visit. We will be happy to bill your insurance if your policy covers a refraction. If you would like to be billed for this service, the fee is \$65 to cover our billing and mailing costs.

Forms: DMV, employer, insurance, or other special forms will be happily filled out for you by Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., These forms are completed after-hours, and will be mailed to you. There is a \$20 charge for completion of forms.

Consent: I consent to necessary medical care and treatment by Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., I authorize release of any medical information necessary to process all claims and request all payments to be made Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I authorize Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., to bill my insurance and receive payment for the duration of my care. I understand that if I am determined not to be eligible for the health care or vision care provided, I agree to pay all charges in full within thirty (30) days of receiving notification. I have read all the information on this sheet. I certify that the information I have provided is true and complete to the best of my knowledge. I will notify you of any changes in the information above or any changes in my health status.

Patient or financially responsible party signature

Date



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NEW PATIENT MEDICAL HISTORY

Patient name: _____ Sex: _____ Age: _____ Date of Birth: _____

Primary Care Physician: _____ Optometrist: _____

Who referred you to this office? _____

PREVIOUS EYE EXAMS AND GLASSES

What do you wear for vision correction? Glasses Reading Glasses Contact Lenses Nothing

Have you had vision correction surgery? No RK PRK LASIK Other _____

Who performed your last eye exam? _____ When? _____

When was your glasses or contact prescription last changed? _____

MEDICAL EYE HISTORY

Please place an "X" next to any of the following eye problems you are currently having:

- | | | | |
|---|------------------------------------|--|---|
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> headaches | <input type="checkbox"/> excessive tearing | <input type="checkbox"/> crossed eyes |
| <input type="checkbox"/> distorted vision | <input type="checkbox"/> itching | <input type="checkbox"/> bump on eyelid | <input type="checkbox"/> wandering eyes |
| <input type="checkbox"/> difficulty reading | <input type="checkbox"/> redness | <input type="checkbox"/> droopy eyelids | <input type="checkbox"/> squinting |
| <input type="checkbox"/> holding things too close | <input type="checkbox"/> pain | <input type="checkbox"/> puffy eyelids | <input type="checkbox"/> double vision |
| <input type="checkbox"/> holding things too far | <input type="checkbox"/> discharge | <input type="checkbox"/> floaters | <input type="checkbox"/> light sensitivity |
| <input type="checkbox"/> eye discomfort | <input type="checkbox"/> scratchy | <input type="checkbox"/> flashing lights | <input type="checkbox"/> other (list below) |

Please indicate with an "X" whether or not you have ever had any of the following eye conditions:

- | | | |
|--|---|--|
| <input type="checkbox"/> cataract | <input type="checkbox"/> retinal detachment | <input type="checkbox"/> lazy eye (amblyopia) |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> macular degeneration | <input type="checkbox"/> crossed eyes (strabismus) |
| <input type="checkbox"/> corneal disease | <input type="checkbox"/> eyelid problem | <input type="checkbox"/> other (please list) _____ |

Have you ever had any eye surgery? No. If yes, please list type, which eye, and approximate date.

_____	_____	_____	_____	_____	_____
type	eye	date	type	eye	date

FAMILY EYE HISTORY

Do you have a family history of any of the following? No. If yes, indicate which relative(s)

- | | | |
|--|---|--|
| Relationship | Relationship | Relationship |
| <input type="checkbox"/> cataract _____ | <input type="checkbox"/> retinal detachment _____ | <input type="checkbox"/> lazy eye (amblyopia) _____ |
| <input type="checkbox"/> glaucoma _____ | <input type="checkbox"/> macular degeneration _____ | <input type="checkbox"/> crossed eyes (strabismus) _____ |
| <input type="checkbox"/> corneal disease _____ | <input type="checkbox"/> eyelid problem _____ | <input type="checkbox"/> other (please list) _____ |

EYE MEDICATIONS

Please list all prescription and non-prescription eye medications you are currently using, which eye, and how often.

Name	which eye	how often	name	which eye	how often
Name	which eye	how often	name	which eye	how often

ALLERGIES

None. If yes, please list: _____

GENERAL MEDICAL HISTORY

Please list all non-eye medications you are taking (e.g. heart medications, blood pressure medications, aspirin, vitamins)

name	how often	name	how often	name	how often
name	how often	name	how often	name	how often

Please list all surgeries you have had and the approximate year they were done.

name	date	name	date	name	date
name	date	name	date	name	date

Have you ever had a bleeding problem? No. If yes, please describe: _____

Have you or a blood relative ever had a problem with anesthesia? No. If yes, please describe: _____

Please indicate with an "X" whether or not you personally have ever had any of the following medical conditions:

- | | | | |
|---------------------------|---------------------|------------------|------------------------|
| ___ diabetes | ___ stroke | ___ cancer | ___ AIDS or HIV |
| ___ high blood pressure | ___ kidney disease | ___ hepatitis | ___ poor hearing |
| ___ heart disease | ___ liver disease | ___ arthritis | ___ headaches |
| ___ asthma or emphysema | ___ thyroid disease | ___ tuberculosis | ___ autoimmune disease |
| ___ extreme weight change | | | |

Tobacco use: No. If yes, number of packs per day: _____

Alcohol use: Never Occasional Weekly Daily

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following? No. If yes, indicate which relative(s)

- | | | | |
|---------------------------|---------------------|------------------|------------------------|
| ___ diabetes | ___ stroke | ___ cancer | ___ AIDS or HIV |
| ___ high blood pressure | ___ kidney disease | ___ hepatitis | ___ poor hearing |
| ___ heart disease | ___ liver disease | ___ arthritis | ___ headaches |
| ___ asthma or emphysema | ___ thyroid disease | ___ tuberculosis | ___ autoimmune disease |
| ___ extreme weight change | | | |

Relationship to patient: _____

Signature of person completing form _____ Date _____



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date of Request _____

Patient's Name (please print)

Address

City

State

Zip Code

Date of Birth

Social Security Number

I hereby request that my medical records be released to:

TO **FROM**

Babak Shabatian, M.D.

Ranjeet Bajwa, O.D.

Phoenix Tran, O.D.

Keely Toma, O.D.

TO **FROM**

Physician/ Optometrist's Name

Address

Telephone/Fax

I also give my permission to Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., to send a summary of his/her findings and treatment plan regarding my eye examination to my primary care physician and referring eye care specialist for continuity of care. I acknowledge that this permission can be limited or cancelled at any time at my request.

Signature of Patient

Date

Signature of Person Acting on Behalf of Patient

Date



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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., use and disclose protected health information (PHI) about me in order to carry out treatment, payment, and healthcare operations (TPO).

Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., office may call my home or other locations and/or persons _____ and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

I give my consent for Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., office to mail, or e-mail my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained in the front desk.

I have the right to request that Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., restrict how he/she uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound in this agreement.

By signing this form, I hereby consent to Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Babak Shabatian, M.D., Ranjeet Bajwa, O.D., Phoenix Tran, O.D., Keely Toma, O.D., may decline to provide treatment to me.

I acknowledge that I have read (or had the opportunity to read) the Privacy Notice.

Signature of Patient or Legal Guardian

Print Name of Patient

Print Name of Legal Guardian, if applicable

Date