PATIENT INFORMATION

Welcome to the office of
Dr. Sergio A. Guzman

Date_____

Name_____ (Mr. Mrs. Miss Ms. Dr.)
Last First M.I.

Street Address: _____
Street City / State / Zip

Mailing Address_____
Street City / State / Zip

Phone: Home_____ **Cell**_____ **Work**_____

Birthday_____ **Soc. Sec. #**_____ **Sex: M/F**

Employer_____ **Occupation**_____

Guarantor of This Account _____ **Soc.Sec #** _____ **D.O.B**_____

Name and Address of relative not living with you:_____

_____
Street City/State/Zip Phone

Vision Insurance: Yes / No (Circle One) **Name of Insurance Co.**_____

Insurance Policy Holder **Relation To Patient** _____

Name_____ **Date of Birth**_____
Last First

Mailing Address_____
Street City / State / Zip

Employer_____ **Occupation**_____ **Soc. Sec. #**_____

Phone: Home_____ **Cell**_____ **Work**_____

How or whom were you referred to this office? _____

I have read all of the above information and certify this information is true and correct to the best of my knowledge.

SIGNED_____ April 2015

FINANCIAL POLICY

We strive to provide the best service and highest quality materials available. It is important to understand our policies in regard to services, materials and payment thereof to prevent any confusion and provide you with the best service possible.

Services & Materials

• A 50% deposit is required to order all materials, with the balance due at the time materials are received.

•All professional service fees are due at the time service is rendered.

• In the event you are unable to come into the office in person to order materials (for example contact lenses) you may order over the phone with a credit card.

• If you wish to have any materials mailed to you they will be sent UPS Ground a service charge of up to $15 can be applied. Location Dependant.
• Returned check fee will be $40

Insurance

• We will make every effort to work with your insurance company to help you receive the maximum benefits you are entitled. A copy of your insurance card is required at the time of your first appointment and anytime thereafter that you change insurance companies. However, it is important to understand that the final responsibility for payment of services and materials belongs to the patient and not their insurance company. The obligation of your insurance is to pay for services within 30 days. It is in your best interest to call them and question any delay.

We can not accept Medicare as a secondary insurance, and we are able to bill primary and secondary insurance only. If you do not know which is your primary insurance you will be responsible for payment.

• *Alternative methods of payment will be assessed on an individual basis. We make every effort to reach to an agreed upon method of payment.*

I have read the above policy and agree to comply with its provisions. I understand that I am responsible for payment for all services rendered. I authorize the release of any medical or other information necessary to process an insurance claim. I hereby authorize insurance payment directly to Dr. Sergio A. Guzman. I understand and agree that I am responsible for my account and am aware that any unpaid balances are subject to finance charges. I also understand that I am responsible for any legal or collection procedure fees. Collection or procedures fees will be as much or equal to the amount owed to Dr. Sergio A. Guzman. All materials left over 120 days will be treated as abandoned and will be donated to the charity of our choice. All money put down will be forfeited and will not serve as future credit.
4/15

Date_____ Signature_____

Dr. Sergio A. Guzman, Ltd. • Optometrist

1184 College Avenue • Elko, Nevada 89801 • (775) 777-3937

WHAT IS A DILATED EXAMINATION?

A dilated examination is one in which eye drops make the pupil of the eye larger. This allows the doctor to view a larger area of the Retina, the interior lining of the eye. It also allows the doctor to check much more thoroughly for Cataracts, Diabetic eye disease, and any indications of Glaucoma or other eye disease.

****A Dilated Exam is no additional charge and takes about 20-30 minutes longer than a non-dilated examination.

WHO NEEDS A DILATED EXAM?

If you are a patient new to our practice or have a personal or family history of eye health problems, the Optometrist may suggest dilating your eyes. Certain conditions may increase your risk for eye health problems. For example, if you are diabetic or highly nearsighted, we may recommend a dilated examination. Your age and other factors may also indicate that dilation is needed.

WILL I BE ABLE TO DRIVE?

We use a new medication to dilate the pupils. This drop acts quickly to dilate the pupils and wears off over several hours. Although the pupils will stay large for several hours, *most* patients have no difficulty driving. You will be more sensitive to light, so we recommend that you wear sunglasses after a dilated exam. If you do not have sunglasses, we will provide you with a pair.

I have read and understand the above information. I give the doctor my consent to dilate my pupils. YES

_____
Patient or Guardian (if under 18) Signature

_____
Date

OR

I have read and understand the above information. I choose not to have my pupils dilated today. NO

_____
Patient or Guardian (if under 18) Signature

_____
Date

Toll Free (888) 773-3937 • Fax (775) 777-3334

Date.	Name:	
	DOB:	Age:

Medical History: Review of Systems

(Please indicate if any of the following medical conditions pertain to you)

Eyes:	Yes		No	Constitutional:	Yes		No
glaucoma	☐	√		development disability	☐	√	
cataract	☐		☐	unintended weight loss	☐		☐
macular degeneration	☐			persistant fever	☐		
inflammation	☐			chronic fatigue	☐		
vision disturbances	☐			trauma	☐		
blurry vision	☐			other	☐		
dry or watery eyes	☐						
infections	☐						
other	☐						
Cardiovascular:	Yes		No	**Musculoskeletal:**	Yes		No
heart disease	☐	√		muscle/joint pain	☐	√	
high blood pressure	☐			muscle spasms	☐		
stroke	☐		☐	muscle weakness	☐		☐
vascular disease	☐			muscle/joint swelling	☐		
other	☐			arthritis	☐		
				other	☐		
Endocrine:	Yes		No	**Gastrointestinal:**	Yes		No
diabetes	☐	√		diarrhea/contispation	☐	√	
hormonal dysfunction	☐			vomiting	☐		
cholesterol/lipid problems	☐		☐	heartburn/ ulcer	☐		☐
cancer	☐			cancer	☐		
other	☐			other	☐		
Respiratory:	Yes		No	**Allergic/Immunologic**	Yes		No
emphysema	☐	√		allergies	☐	√	
pneumonia	☐			rheumatoid arthritis	☐		
asthma	☐		☐	lupus	☐		☐
bronchitis/cough	☐			autoimmune disease	☐		
cancer	☐			other	☐		
other	☐						
Blood/Lymphatic:	Yes		No	**Integumentary (skin):**	Yes		No
anemia	☐	√		eczema/dermatitis	☐	√	
bleeding problems	☐			rosacea/acne/psoriasis	☐		
leukemia	☐		☐	cysts/warts/ulcer	☐		☐
other	☐			cancer	☐		
				other	☐		
Nervous System:	Yes		No	**Mental:**	Yes		No
seizures	☐	√		depression	☐	√	
multiple sclerosis	☐			panic/anxiety disorders	☐		
head-aches/migraines	☐		☐	mood changes	☐		☐
paralysis	☐			psychoses	☐		
numbness/ cold	☐			amnesia/sleep disorders	☐		
other	☐			other	☐		
Ears/Nose/Throat	Yes		No	**Genitourinary:**	Yes		No
runny nose/ hay fever	☐	√		genital/prostate	☐	√	
sinus congestion	☐			kidney/bladder	☐		
dry mouth/throat	☐		☐	overy/uterus/vaginal	☐		☐
cancer	☐			cancer	☐		
other	☐			other	☐		

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RECORDS RELEASE

DATE: _____

TO: _____
Doctor's Name and/or Facility Name

_____
Address

I hereby authorize you to release any and all information including diagnosis and records of treatment and/or examinations rendered to me during the period:

_____ to _____

Please mail or fax all information mentioned above to:

Sergio A. Guzman, O.D.
Doctor's Name and/or Facility Name

1184 College Avenue Elko, Nevada 89801
Doctor and/or Facility Address

The facility, staff, and optometrists are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____
Name of Patient Patient's Signature

_____ _____
Patient's Date of Birth Patient Address

Witness Signature: _____

Authorization for records release expires one year after today's date.

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Social History:

Do you have visual difficulty when driving? Yes ☐ No ☐ If yes, please explain:_____

_____

Do you use tobacco products? Yes ☐ No ☐ If yes, type/amount/how long:_____
Do you drink alcohol? Yes ☐ No ☐ If yes, type/amount/how long:_____
Do you use addictive agents? Yes ☐ No ☐ If yes, type/amount/how long:_____

Have you been infected with: Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None ☐

Past History:

Do you take medications (including prescriptions, oral contraceptives, aspirin, over the counter medications and home remedies): Yes ☐ No ☐
If yes, please list:

_____

_____

Have you had past injuries? Yes ☐ No ☐ If yes, please list: _____

Have you had past surgery? Yes ☐ No ☐ If yes, please explain: _____

Are you currently pregnant? Yes ☐ No ☐ If yes, expected due date? _____

Are you allergic to any medications: Yes ☐ No ☐
If yes, please list:

_____

Family History:

Please check box if anyone in the family (parents, grandparents, brothers/sisters, or children) has had any of the following conditions:

	Yes	No		Yes	No
Blindness	☐	☐	Diabetes	☐	☐
Cataract	☐	☐	Heart Disease	☐	☐
Crossed Eyes	☐	☐	High Blood Pressure	☐	☐
Glaucoma	☐	☐	Kidney Disease	☐	☐
Macular Degeneration	☐	☐	Lupus	☐	☐
Retinal Detachment/Disease	☐	☐	Thyroid Disease	☐	☐
Arthritis	☐	☐	Other	☐	☐
Cancer	☐	☐			

Patient Signature	Date	Initial if No Change