Aesthetic Eyecare Associates
David Wirta, M.D. Ira Vidor, M.D.

Last Name: _____First: _____MI_____ Date of Birth: _____Age_____

Address:_____City _____State _____ZIP_____

Home#_____ Cell# _____Work# _____

Email: _____ By providing contact information, I authorize Aesthetic Eye Care Institute to leave a message in reference to any items that assist the practice in carrying out healthcare operations.

Gender: _____ Marital Status: _____ Last 4# SS_____ (used to get insurance authorization)

Pharmacy: _____ Phone# _____

Who may we thank for your referral? Physician Name: _____
Family / Friend referral? Name: _____
Internet_____ Insurance Directory_____ Other_____

Primary Care Physician (THIS IS IMPORTANT>PLEASE PROVIDE THIS INFORMATION SO THAT WE MAY SEND A CONSULTATION REPORT) Please include first and last name

Dr_____ Address _____
* First and Last Name Please * If you do not have complete address, please at least include city

Phone Number:_____Fax number:_____

Emergency Contact Name: _____ Relationship_____ PH#_____

Spouse Name: _____ Date of Birth: _____ PH#_____

Insurance Information: - Names only – we will be requesting card copies

PRIMARY INSURANCE NAME:_____please write none if applicable

2nd INSURANCE NAME:_____please write none if applicable

Who is responsible for this account: _____ Relationship to patient: _____

WE **ARE NOT PROVIDERS** OF *MEDI-CAL and we do not accept any Covered California Insurance Plans. We will bill insurance in lieu of payment despite the fact that you may have a deductible. We must however ask you to pay your balance due within 10 days of your 1st statement date.

Patient Signature:_____Date:_____

Parent Signature / Responsible Party:_____Date:_____

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MEDICAL QUESTIONNAIRE

PATIENT NAME: _____ DATE OF BIRTH_____

Medication- We have provided a separate sheet to list all Medications (prescribed and over the counter) Please be sure to
include all prescribed medication, over the counter medication, herbal supplements and vitamins. Please include strength and dosage.
Do you have allergies to any medications? YES / NO Please provide list:
Name of Optometrist / Previous Ophthalmologist:
Ocular History / Ocular Surgery (example: cataract, glaucoma)
Major Surgery: (last 10 years example: heart, orthopedic)

PATIENT MEDICAL HISTORY

List all major illnesses, (diabetes, high blood pressure, heart attack, etc.) and injuries

	YES	NO	Details
	☐	☐	
EARS, NOSE, THROAT (hard of hearing)	☐	☐	
CARDIOVASCULAR (high blood pressure, racing pulse)	☐	☐	
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)	☐	☐	
GASTROINTESTINAL	☐	☐	
GENITAL, KIDNEY, BLADDER	☐	☐	
FEMALES Are you pregnant? Nursing?	☐	☐	
MUSCLES, BONES, JOINTS (Arthritis)	☐	☐	
SKIN	☐	☐	
NEUROLOGICAL (Stroke)	☐	☐	
PSYCHIATRIC (anxiety, depression, insomnia)	☐	☐	
ENDOCRINE (diabetes, hypothyroid, etc.)	☐	☐	
BLOOD / LYMPH (bleeding, anemia)	☐	☐	
ALLERGIC / IMMUNOLOGIC (allergies)	☐	☐	

Family History (Please specify family member)	Mother	Father	Other family Member	Approximate age of onset
Cataract - Glaucoma - Macular Degeneration	☐	☐		
Diabetes I - Diabetes II - Hypertension	☐	☐		
Heart Disease - Thyroid disease - Arthritis	☐	☐		
Cancer- list type	☐	☐		

SOCIAL HISTORY

Vaccination status: Pneumonia vaccination (65yrs older) Yes / No
Healthcare Proxy (a person appointed to make healthcare decisions on your behalf you are incapable: Yes / No
Living Will (a written statement detailing your medical treatment desires if you are incapable: Yes / No
Smoking Status: Have you ever smoked? Yes / No How Long
Do you drink alcohol? Yes / No How Often

Patient Signature Date

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MEDICATION LIST

Patient Name: _____ Date: _____

Please list ANY and ALL medications you take, including over the counter medicines, herbal supplements and vitamins.

Medication (Vitamin or supplement)	**Dose**	**How many times a day do you take it?**	**What condition do you take this medication for?**	**Start Date**

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PRIVACY & HIPPA CONSENT FORM

Patient Name: _____ Date: _____

Release of Medical Information: I authorize the release of all medical information and/or financial ledger to any person or corporation (1) which is or may be liable or under contract with my medical insurance for reimbursement for services rendered, and (2) any health care provider for continued care. My signature authorizes release of the information to the insurer or agency shown. Initials: _____

Assignment of Benefits: I authorize David Wirta, M.D. / Ira Vidor, M.D. to bill my insurance on my behalf. I assign payment of medical benefits for services rendered to David Wirta, M.D. / Ira Vidor, M.D. I understand that it may be necessary to supply my insurance company with a copy of my insurance card, medical and or personal information about myself in order to process insurance claims. Initials: _____

Medicare Patients Only: Please sign below so that we may bill Medicare on your behalf. I authorize David Wirta, M.D. / Ira Vidor, M.D., a holder of my medical information to release information about me to the Centers for Medicare and its agents or its intermediaries or carrier, any information needed for this or related Medicare claims/ benefits payable for related services. I understand that my signature requests that payment of medical insurance benefits be paid to this provider of service and authorizes release of medical information necessary to pay the claim. David Wirta, M.D / Ira Vidor, M.D. accept the charge determination of the Medicare carrier as the full charge and I understand I am responsible for the 20% due after Medicare payment plus any remaining deductible. This authorization is valid until revoked in writing. Initials: _____

Non-Covered Services: I understand that David Wirta, M.D. / Ira Vidor, M.D. contract with health care service plans (Medicare, HMO's PPO's) for medically necessary services. Services considered cosmetic or refractive are not considered medically necessary and are the responsibility of the patient. Payment in full will be collected at the time of the pre-operative appointment. Initials: _____

Financial Agreement: I agree that in return for the services provided, it is my responsibility to provide this office with correct insurance information / insurance card. I understand medical insurance (for medically covered services) will be billed on my behalf in lieu of payment despite the fact that I may have a deductible. After billing my insurance company, I agree to pay my balance due (deductible amount and/or deductibles) within 10 days of my statement billing date. I understand that I may be charged interest at the legal rate. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. Payment methods include: Cash, Check, Visa, Mastercard, Discover Card. **Please note that we are not providers of: Medi-cal and do not accept any Covered California Plans** Initials: _____

Private Practices (HIPAA): Please ask our staff for a copy of the privacy practices notice. Please sign below to acknowledge access to the Notice of Privacy Practices for the office of David Wirta, M.D. / Ira Vidor, M.D. This Notice of Privacy Practices provides information about how we use and disclose your protected health information. We encourage you to read this notice in full. This Notice of Privacy Practice is subject to change. You may request a copy of this notice at any time. Please sign below to document that this Notice of Privacy Practices has been made available to you and that you are aware that a copy of this notice is available to you upon request. Initials: _____

Signature: _____Date: _____
Please list any persons to whom your protected health information can be disclosed or discussed: We cannot talk about you with any person who is not listed below for ANY reason.

Name:_____Relationship:_____

Name:_____Relationship:_____