DANIEL F. GOODMAN, M.D.
2211 BUSH STREET, 2nd Floor
SAN FRANCISCO, CA 94115

PATIENT INFORMATION ☐ **Checked ID**

Dr./Mr./Mrs./Miss/Ms. _____
Last Name *First Name* *Middle Initial*

*ADDRESS _____ *CELL PHONE ( ) _____
Street *HOME PHONE ( ) _____

_____ *EMAIL: _____
City *State* *Zip*

**Messages disclosing information regarding appointments, billing communications, clinical call backs, etc. will be left at the provided contact numbers and addresses unless otherwise indicated.*

Preferred name (if different than listed above): _____

Please Circle M F S M W D DP SS # _____ Birthdate: _____ Age_____
Sex *Marital Status*

EMPLOYER _____ OCCUPATION _____
(If retired, from what occupation?)
ADDRESS _____ WORK PHONE ( ) _____
Street *City* *State* *Zip*

SPOUSE _____ DAYTIME PHONE ( ) _____
EMERGENCY CONTACT _____ DAYTIME PHONE ( ) _____

PERSONAL PHYSICIAN _____ PHONE ( ) _____
ADDRESS_____ E-Mail _____
Street *City* *State* *Zip*

IF PATIENT IS A CHILD:
FATHER'S NAME _____ MOTHER'S NAME _____
FATHER'S SSN _____ MOTHER'S SSN _____

INSURANCE INFORMATION *(please give insurance card to receptionist for copying)*

Primary Insurance	*Name of Insured*	*Policy Id #*	*Group #*	*Co-Pay*
Secondary Insurance	*Name of Insured*	*Policy Id #*	*Group #*	*Co-Pay*

WHOM MAY WE THANK FOR THIS REFERRAL?

☐ Doctor: _____
Name
_____
Address

☐ Friend: _____
Name

☐ San Francisco Giants ☐ KRON 4
☐ San Francisco Magazine ☐ Google
☐ Other _____

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EYE HISTORY:

PLEASE STATE THE MAIN PROBLEM WITH YOUR EYES: _____

_____

WHEN DID THIS PROBLEM START? RIGHT EYE_____ LEFT EYE _____

CURRENT EYE MEDICATIONS:

NAME	DOSE	HOW OFTEN?	HOW LONG HAVE YOU BEEN USING THIS?

WHICH EYE (IF EITHER) DO YOU FEEL IS "DOMINANT" (WHICH EYE DO YOU USE TO SHOOT A CAMERA?)

RIGHT _____ LEFT _____

WHEN WAS YOUR FIRST EYE OR VISION EXAM AND WHY WERE YOU SEEN? _____

_____

DO YOU WEAR CONTACT LENSES? _____ FOR HOW LONG? _____ LAST REPLACED _____

TYPE OF LENSES WORN: SOFT _____ HARD_____ DAILY WEAR _____ EXTENDED WEAR _____ DISPOSABLE _____

WHEN WAS THE LAST DAY (DATE) THAT YOU WORE YOUR CONTACT LENSES? _____

WHEN DID YOU GET YOUR FIRST GLASSES AND WHAT WERE THEY FOR? _____

_____

WHEN WERE YOUR GLASSES LAST CHANGED? _____

WHEN DID YOU GET YOUR FIRST BIFOCALS? _____

WHEN WAS YOUR LAST VISIT TO YOUR EYE DOCTOR PRIOR TO YOUR PRESENT PROBLEM? _____

HAVE YOU EVER HAD ANY OTHER EYE PHYSICIANS? IF SO, THEN PLEASE LIST NAME(S) OF THE MOST RECENT: _____

_____

DO YOU HAVE, OR HAVE YOU EVER HAD: (Circle Yes or No)

Yes	No	BLURRED OR REDUCED VISION?	Yes	No	NIGHT TIME DIFFICULTIES
Yes	No	KELOID FORMATION?			GLARE OR HALOES?
Yes	No	ANY EYE INFECTIONS?	Yes	No	EYE PAIN?
Yes	No	ANY EYE INJURY?	Yes	No	ANY EYE SURGERY?
Yes	No	FOREIGN BODY IN EYE?	Yes	No	GLAUCOMA?
Yes	No	ANY EYE DROPS OR MEDICATIONS?	Yes	No	OTHER EYE PROBLEMS?

HAVE YOU EVER WORN "MONOVISION" CONTACT LENSES? _____ (NEAR VISION _____ EYE)

MEDICAL HISTORY:

DO YOU HAVE ANY ILLNESSES? (HIGH BLOOD PRESSURE, DIABETES, ARTHRITIS, HEART DISEASE, BRONCHITIS, ASTHMA, ETC.)_____

_____

LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICINES:

NAME	HOW MUCH?	HOW OFTEN?	HOW LONG?	WHAT FOR?

ARE YOU **ALLERGIC** TO ANY MEDICINES (IF SO, PLEASE LIST)_____

HAVE YOU EVER HAD COSMETIC/PLASTIC SURGERY? (IF SO, LIST TYPE) _____

_____

EVER SMOKE? _____ HOW MUCH? _____ ALCOHOL INTAKE? _____

SPECIAL DIET? _____

WHERE WERE YOU BORN AND RAISED? _____

LIST CHRONOLOGICALLY ALL HOSPITALIZATION AND/OR OPERATIONS YOU HAVE HAD:

DATE	PURPOSE OF HOSPITALIZATION OR TYPE OF OPERATION

DO YOU HAVE, OR HAVE YOU EVER HAD: (Circle Yes or No)

Yes	No	ANY OTHER ALLERGIES?	Yes	No	DIGESTIVE PROBLEMS?
Yes	No	ASTHMA?	Yes	No	ULCERS?
Yes	No	HAY FEVER?	Yes	No	KIDNEY PROBLEMS?
Yes	No	HIGH BLOOD PRESSURE?	Yes	No	GENITOURINARY PROBLEMS?
Yes	No	ARTHRITIS?	Yes	No	SKIN PROBLEMS?
Yes	No	HEART PROBLEMS?	Yes	No	ANEMIA?
Yes	No	BREATHING PROBLEMS?	Yes	No	BLOOD PROBLEMS?
Yes	No	ANKLE SWELLING?	Yes	No	STROKE?
Yes	No	TUBERCULOSIS?	Yes	No	VENEREAL DISEASE?
Yes	No	TUMOR OR CANCER?	Yes	No	LIVER PROBLEMS?
Yes	No	SERIOUS INJURY?	Yes	No	STEROIDS OR
Yes	No	HORMONAL PROBLEMS?			ANTICOAGULANTS?
Yes	No	ARE YOU PREGNANT OR NURSING?	Yes	No	HIV POSITIVE?
Yes	No	KELOID FORMATION?	Yes	No	HEPATITIS POSITIVE?

Yes No ANY SERIOUS ILLNESSES, DISEASE, OR CONDITIONS NOT MENTIONED? PLEASE DETAIL:

_____

_____

_____

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MEDICAL HISTORY (PAGE 2)

NAME YOUR OTHER PHYSICIANS AND WHY YOU SEE THEM:_____

_____

_____

WHEN WAS YOUR LAST VISIT TO YOUR GENERAL PHYSICIAN, AND WHAT WAS IT FOR?

_____

_____

WHAT WERE THE DOCTOR'S FINDINGS?

_____

_____

WHAT IS THE GENERAL STATE OF YOUR HEALTH?

_____

_____

FAMILY HISTORY: HAS ANYONE IN YOUR FAMILY EVER HAD: (Circle Yes or No)

Yes	No	CATARACT?	Yes	No	ANY EYE OPERATION?
Yes	No	GLAUCOMA?	Yes	No	MACULAR PROBLEMS?
Yes	No	RETINAL DETACHMENTS?	Yes	No	OTHER FAMILY EYE PROBLEMS?
Yes	No	BLINDNESS?	Yes	No	DIABETES?
Yes	No	CANCER?	Yes	No	HIGH BLOOD PRESSURE?
Yes	No	DID YOUR PARENTS SEE WELL?	Yes	No	ANY HEREDITARY OR FAMILIAL DISEASES OR CONDITIONS?

IS THERE ANYTHING ELSE YOU FEEL IS IMPORTANT ABOUT YOU, YOUR HEALTH, OR YOUR EYES?

_____

_____

_____

THANK YOU.

Financial Policy

If you have a medical insurance or Vision Service Plan (VSP), we are committed to helping you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy.

- As a courtesy to our patients, our office will file with your insurance. However, you are responsible for any unmet deductible, coinsurance or copays and any non-covered services. In order for us to file your claim in a timely manner a copy of your Medicare and/or insurance card will be needed as well as your referral from your primary care physician, if required by your insurance carrier.

- It is your responsibility to know your insurance coverage and to provide our office with the most current and accurate information. While our staff is extremely knowledgeable about many insurance plans, we are not aware of every plan and their specific details since they constantly change. We are not liable for misquoted benefits or eligibility.

- The determination of your best corrected vision is called a refraction. This is considered a non-covered service/procedure by most ***medical*** insurance companies. If this service is not covered, you will be responsible this service fee of $50.

- If your insurance requires a referral, you are responsible for contacting your primary care physician/pediatrician to obtain said referral prior to beginning your appointment. If a referral is not obtained, you will be responsible for the services. It is also your responsibility to verify that valid referrals are on file for any follow up care.

I understand that even if Dr. Goodman is contracted with my health care plan, I am responsible for payment of both covered and non-covered services performed during the course of my treatment. I authorize release of medical information to the insurance carrier or its agents to allow for benefit or claim determination.

Signature of Responsible Party: _____ Date: _____

Acknowledgement of Receipt of Patient Notice of Privacy Practices

I acknowledge that I read and/or received a copy of the *Goodman Eye Center* Notice of Privacy Practices. I understand that the Goodman Eye Center HIPAA Policy Binder and additional copies of the Notice of Privacy Practices are available to me at any time. I have no objection to appointment reminder messages by email or text.

Signature of Responsible Party: _____ Date: _____