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

PATIENT INFORMATION

Dr./Mr./Mrs./Miss/Ms. ____
Last Name First Name Initial

ADDRESS ______________________________ HOME PHONE ( ) ____________
Street
______________________________ Email: ____________
City State Zip

Please Circle M F (Sex) S M W D DP (Marital Status) SS # ____________ Birthdate: ____________ Age_____

EMPLOYER ______________________ OCCUPATION ______________________
(If retired, from what occupation?)
ADDRESS ______________________________ WORK PHONE ( ) ____________
Street City State Zip CELL PHONE ( ) ____________

SPOUSE ______________________________DAYTIME PHONE ( ) ____________
RELATIVE/FRIEND ______________________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?

NAME: ______________________ PHONE: ( )____________ E-MAIL: ______________________

ADDRESS:____
Street City State Zip

DANIEL F. GOODMAN, M.D.

<u>EYE HISTORY</u>:

PLEASE STATE THE MAIN PROBLEM WITH YOUR EYES: ____

____

WHEN DID THIS PROBLEM START? RIGHT EYE________________________ LEFT EYE ______________________________

PRESENT EYE MEDICATIONS:

<u>NAME</u> <u>DOSE</u> <u>HOW OFTEN?</u> <u>HOW LONG?</u>

____

____

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 ________________________

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 GLARE OR HALOES?
Yes	No	KELOID FORMATION?			
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)

DANIEL F. GOODMAN, M.D.

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:

____

____

____

____

DANIEL F. GOODMAN, M.D.

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

PATIENT'S NAME: ______________________________________ **DATE:** _______________

I have been informed that my insurance company may not cover refractions (92015) in which case I agree to be fully responsible for the charge of **$50.00**.

Payment is due at the time of service. Persons who carry medical insurance should remember that professional services are rendered and charged to the patient and not the insurance company. We will gladly assist you in preparing necessary forms to expedite your insurance claims.

I hereby request that payment of authorized Medicare benefits, or any other insurance that I have, be made on my behalf to Daniel F. Goodman, M.D. for any services furnished me by this physician/provider. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents or any other insurance company any information needed to determine these benefits or the benefits payable for related services. **I ALSO AGREE TO PAY FOR ALL "NON-COVERED SERVICES", INCLUDING REFRACTIONS AND CONTACT LENSES.**

In addition, I consent to evaluation and treatment as necessary for care, including but not restricted to whatever drugs or studies that may be used by Daniel F Goodman, M.D., or qualified designate.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

SIGNATURE: ____ DATE ______________________