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 ______________________________________ HOME PHONE ( ) ____________________
Street Apt
CELL PHONE ( ) ____________________

____
City State Zip

EMAIL: ______________________________________

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 ( ) ____________________
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.

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? _________ WHEN WAS THE LAST TIME YOU WORE THEM? ________________________ #

TYPE OF LENSES WORN: SOFT_______ GAS PERMEABLE______

HAVE YOU EVER WORN "MONOVISION" CONTACT LENSES? _________ (NEAR VISION IN THE ____________ EYE) #

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

____

WHEN WERE YOUR GLASSES LAST CHANGED? ____ #

WHEN WAS YOUR LAST EYE EXAM AND WHO WAS IT WITH? ____ #

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

Yes #	No	BLURRED OR REDUCED VISION?	Yes	No	ANY EYE INFECTIONS?
Yes	No	NIGHT TIME DIFFICULTIES, GLARE/HALOS?	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?

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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 ANTICOAGULANTS
Yes	No	HORMONAL PROBLEMS			
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)

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

____

____

WHAT WERE THE DOCTOR'S FINDINGS?

____

____

NAME YOUR OTHER PHYSICIANS AND WHY YOU SEE THEM

____

____

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

Yes #	No	CATARACT	Yes	No	DIABETES #
Yes #	No	GLAUCOMA	Yes	No	HIGH BLOOD PRESSURE? #
Yes #	No	RETINAL DETACHMENTS	Yes	No	CANCER #
Yes #	No	BLINDNESS	Yes	No	ANY HEREDITARY OR FAMILIAL
Yes	No	MACULAR PROBLEMS			DISEASES OR CONDITIONS #
Yes #	No	ANY EYE OPERATION #			
Yes #	No	CORNEAL IRREGULARITIES SUCH AS #			
		KERATOCONUS OR CORNEAL DYSTROPHIES #			
Yes #	No	CORNEAL TRANSPLANT			

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

____

____

____

THANK YOU

PATIENT'S NAME: ______________________________ **DATE:** ____________

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 BUT NOT LIMITED TO REFRACTIONS AND CONTACT LENS RELATED SERVICES.**

I have been informed that my insurance company may not cover refractions (CPT 92015) in which case I agree to be fully responsible for the charge of **$85.00**.

In addition, I consent to evaluation and treatment as necessary for care, including but not restricted to whatever drugs, studies, or procedures 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 ________________

2211 Bush Street, Second Floor, San Francisco, CA 94115 #
***Ph:* 415-474-3333 *FAX:* 415-474-3939** #
***Website*: www.goodmaneyecenter.com** #