W. Andrew Cies, M.D., F.A.C.S.
Ophthalmology
400 Newport Center Dr, Suite 404
Newport Beach, CA 92660
949-640-2023

NEW PATIENT REGISTRATION

Name(Last, First MI)____**Marital Status** M S D W

Address____

City_______________________________________**State**_____________**Zip**_______________

Home Phone(________)________________ **Work**(_______)_________________

Cell Phone(________)_________________ **E-Mail** ___________________________________

Date of Birth_________________ **Age**_______ **Sex** M F **Social Security #**___________________

Employer/Occupation____

Employer Address____

City_______________________________________**State**_______________**Zip**______________

Nearest Friend/Relative (not living with you)____

Phone # (________)_____________________

Responsible Party if other than patient____

Phone(________)________________ **Relationship to Patient**______________________________

Address____

City_______________________________________**State**_______________**Zip**______________

Employer Address_____________________________ **Employer Phone**______________________

Referred by___________________________________ **Family Physician**____________________

***We will courtesy bill your insurance policy based on the information you provide for us.**
***If we are not a contracted provider with your insurance policy, you will be responsible for the balance at the time services are rendered.**
***How do you wish to pay for today's visit?** Cash Check Visa Mastercard

INSURANCE INFORMATION

Primary Insurance____

Name of Policyholder____________________________ **Relationship to patient**_______________

Secondary Insurance____

Name of Policyholder____________________________ **Relationship to patient**_______________

Eye History

Please list the eye problems(s) you have and for how long:

ANSWER EACH QUESTION BELOW:

When was your last eye exam?________________
Do you wear contact lenses? Y N Successfully? Y N
Do you want contact lenses? Y N
Do you see well with your glasses? Y N
Do you like your glasses? Y N
Would you like new glasses for sun, near, computer, or sports? Y N
Do you want cosmetic eye surgery? Y N
Do you want Laser Vision surgery to improve vision without glasses or contacts? Y N

OCULAR HISTORY

Do you have: cataracts, glaucoma, retinal disease or other eye problems?
Have you had eye surgery? Yes No If yes, what kind?
____
Have you had a prior eye or head injury? Yes No
Explain_______________________

EYE MEDICATIONS (list)
____

____
Do not write below this line --- FOR DOCTORS USE ONLY

Reviewed PmHx/ SocHx/ FamHx from visit of _________________ Initial

Name________________________________Date_____________

SYSTEMIC MEDICAL HISTORY

PAST MEDICAL HISTORY

Injuries____

Hospitalizations____

REVIEW OF SYSTEMS

Do you have or have you had problems with:

Skin Y N _______________________________
Head Y N
____
Ear, Nose, Throat Y N ______________________________
Neck Y N _______________________________
Gastrointestinal Y N _______________________________
Genito-urinary Y N _______________________________
Joints,Bones,Muscles Y N _____________________________
Neurologic Y N _______________________________
Blood/LymphaticY N _______________________________
Allergic/Immunologic Y N _____________________________
Psychiatric Y N _______________________________
Endocrine Y N _______________________________

SPECIFIC PROBLEMS

Heart problems Y N _______________________________
Hypertension Y N _______________________________
Diabetes Y N _______________________________
Arthritis Y N _______________________________
Lung Disease Y N _______________________________
Cancer Y N _______________________________

FAMILY HISTORY (parents, siblings, children) Specify who

Cataract_________________________________
Glaucoma________________________________
Retinal problems (macular degeneration,
retinal detachment)__________________
Lazy or Crossed Eyes______________________

Heart Disease____________________________
Lung Disease____________________________
Diabetes_________________________________
Cancer__________________________________
Arthritis_________________________________
Hypertension____________________________

REVIEWED – NO CHANGE SINCE VISIT ON ______________ INITIAL

Name_____________________________ Date_____________

SYSTEMIC MEDICAL HISTORY

SOCIAL HISTORY

Do you smoke? Y N How much?____________
Did you smoke in the past? Y N For how long?_______
Do you drink? Y N How much/often? _________
Did you drink alcohol in the past?_________
Do you use recreational drugs? Y N
Weight - Gain/No change/Loss ________________
Exercise - None/Occasional/Weekly/Daily

Your Occupation_____________________________________

Your Education______________________________________

ALLERGY -- List allergies to medications

1.
2.
3.

ALL MEDICATIONS - List meds and for what they are being taken

Medicine	Condition treated
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.

Prior Surgeries -- please list (include eye surgery)

Procedure	Date
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

REVIEWED - NO CHANGE SINCE VISIT ON __________ INITIAL

ALL PATIENTS PLEASE READ AND SIGN WHERE APPROPRIATE

TO ALL PATIENTS

One of the most important parts of your eye exam today is the refraction. This is the part of the exam in which we determine the best possible visual acuity & function of your eyes. The refraction is also to evaluate your present glasses and prescribe new ones. Without the refraction, Dr. Cies may not be able to fully assess the health & function of your eyes. This is **NOT** covered by Medicare or other insurance plans. Our office fee for refraction is $60.00 and is collected at the time of service. Please indicate your understanding by signing below.

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ALL CONTACT LENS PATIENTS

If you wish to have your contact lens evaluated, you wish to have a contact lens prescription, or you wish to obtain new contact lens, there is a professional fee for this service in addition to the fee for your eye examination. This fee will range from $75 to $250; additionally there may be an increased professional fee for specialty contact lens fittings such as, Bifocals, Keratoconus or post- surgical patients.

___ ____

INSURANCE PATIENTS

If you wish us to bill your medical or vision insurance, you must have all information with you at the time the service is rendered. Otherwise we will accept cash, credit cards, or checks for payment. We cannot bill your insurance at a later date as too many patients "discover" their insurance after their visit and this creates accounting problems for our staff. This request applies to all insurance plans, including ones' which would normally cover all costs for your visit and glasses. If you are uncomfortable with this arrangement, we will be happy to reschedule your visit at a time when you have your insurance and financial information available. Please indicate your understanding by signing below.

____

VSP PATIENT CONSENT FORM

Patient Name:______________________________ Date of Birth:_______________

I,____________________________, consent Dr. W. Andrew Cies, M.D., Inc., to the release of medical records for the above specified individual to:

VSP
P.O. Box 997100
Sacramento, CA 95899-7100

PLEASE READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon VSP's request to VSP for the purpose of health care operations including but not limited to, provider review functions, claims, payment and quality assessment. I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

For additional information on VSP's Patient Confidentiality Policy, please refer to http://www.vsp.com
VSP updates the Patient Confidentiality Policy periodically and reserves the right to make changes as required.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Signature:________________________________ Date:______________________