

APPT. DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

TIME: \_\_\_\_\_ AM/PM

LOCATION:     333 W. EL CAMINO REAL, SUITE 340, SUNNYVALE  
               9360 NO NAME UNO, #220, GILROY

## **South Bay Retina**

**Keshav Narain, M.D.**

**Vitreoretinal Diseases & Surgery**

*“Changing the world through your eyes.”*

Welcome to South Bay Retina. We are sending you this letter, along with our patient information forms so that you can complete them before coming to the office for your appointment. Having these documents filled out before arriving for your first visit will help shorten the length of time that you are in the office. Please bring all of your medical insurance cards with you, as well as any letters or authorizations for this visit. Also, if you have been referred to our office by your optician, general ophthalmologist, or physician, please bring any notes or referral slips they may have given you. If your insurance plan is HMO, it is required that you have authorization from your primary care doctor to see Dr. Narain, so be sure to review the details of your insurance policy before your appointment; including your deductible requirement and co-pay for an office visit with a specialist, and feel free to call us with any questions you may have.

Your first visit to our office typically takes between one to two hours. Dr. Narain is an ophthalmologist who has done additional sub-specialty training in diseases of the retina. In order for him to achieve the best possible view of your retina (located at the very back of your eye) your pupils will be dilated with special drops. After about 30 minutes, both eyes should be fully dilated for his exam, and this may last between two to six hours. At the end of your visit, we will have sunglasses available for you if you need them and most patients are able to drive themselves home without a problem. If you are not sure if you will be able to drive safely after dilation, please bring someone with you or plan to have someone pick you up from your appointment.

You are encouraged to ask questions to both the staff and the doctor. At the conclusion of your visit, Dr. Narain will send a consultation report to your referring physician and any other doctor or person involved in your care. Please include the names and addresses of all people you would like to have the report sent to.

We look forward to meeting you soon!

~South Bay Retina

## NEW PATIENT REGISTRATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M/F

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell/Other: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Language Preferred: \_\_\_\_\_

If you are listed as a dependent on your insurance policy, please provide the subscriber's information:

Subscriber's / Guarantor's Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Medical Doctor: \_\_\_\_\_

In Case of Emergency, please list nearest relative/friend we may contact:

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

### INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the South Bay Retina, Inc. to furnish information to insurance carriers, and any other physicians involved in my care, regarding my illness and treatments. I hereby assign to the physician all payment for medical services rendered to me. I understand that I am responsible for any amount not covered by the insurance company. I also understand that there will be a fee if I request a paper copy of my medical record.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### OPTIONAL INFORMATION:

(You may choose not to answer the following two questions by checking the "decline" box)

**RACE:** \_\_\_\_\_ Ex.: White, Indian, Other **IF OTHER:** \_\_\_\_\_

**ETHNICITY:**  Not Hispanic/Latino  Hispanic/Latino: \_\_\_\_\_ (Country)

DECLINE TO ANSWER

## NEW PATIENT HEALTH QUESTIONNAIRE

Patient name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First Last

Date of birth: \_\_\_\_\_ Primary Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

### EYE HEALTH HISTORY / SYMPTOMS

Place a mark on "Yes" or "No" to indicate if you have any of the following:

	Yes	No		Yes	No		Yes	No
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Burning Eyes/Pain	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Red eyes	<input type="checkbox"/>	<input type="checkbox"/>
Cataract Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
Central dark spot	<input type="checkbox"/>	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>
Discharge/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____		
Distortion	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Dizzy	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Other symptoms:		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Curtains	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Shadows	<input type="checkbox"/>	<input type="checkbox"/>	_____		

### HEALTH HISTORY / REVIEW OF SYMPTOMS

Place a mark on "Yes" or "No" to indicate if you have any of the following:

	Yes	No	Family History	Yes	No	Family History	Yes	No	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cough/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	Muscle tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (Type ____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>

Tobacco use – Length of use: \_\_\_\_\_

Please list any **medication(s)** or eye drops you are currently taking: \_\_\_\_\_

Please list any **allergies** to medications or other substances: \_\_\_\_\_

Please list any **surgical procedures** you have undergone: \_\_\_\_\_

Primary reason you are here today: \_\_\_\_\_

**Patient signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

SOUTH BAY RETINA, INC.

**KESHAV NARAIN, M.D.**

PHONE: 408-294-3534 FAX: 408-294-3214

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**INFORMATION REGARDING DILATING EYE DROPS**

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. In order for Dr. Narain to properly examine the retina, your eyes must be dilated.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. To make your visit more comfortable, sunglasses are available at the front desk at anytime.

It is not possible for your ophthalmologist to predict how much your vision will be affected. If you feel that driving may be difficult for you immediately after an examination, it's best if you make arrangements not to drive yourself. Your eyes may remain dilated for approximately 4 to 6 hours.

An adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Keshav Narain and/or such assistants, as may be designated by him, to administer dilating eye drops. I understand that the eye drops are necessary to diagnose my condition.

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Patient Signature (or person authorized to sign for patient)

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Date

# MEDICAL RECORDS RELEASE

\_\_\_\_\_  
NAME OF PATIENT

\_\_\_\_\_  
BIRTHDATE

**Authorizes:**

**to Release Records to:**

\_\_\_\_\_  
Name of Physician or Facility

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

**Keshav Narain, MD**

South Bay Retina, Inc.

333 W El Camino Real, Ste 340

Sunnyvale, CA 94087

Fax: (408) 294-3214

**Information to be released:**

Clinical Records

Eye Records

Visual Fields

Allergy Records

Office Notes

X-ray Reports/ Films

Lab Reports

Electrocardiogram

Photographs

Other

List other records to be included when releasing for the purpose of continuing medical care (Include Dates):

\_\_\_\_\_  
\_\_\_\_\_  
I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

**Signature of Patient:** \_\_\_\_\_ **Date** \_\_\_\_\_

If signed by person other than patient, state relation:

**Authorized Signature** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY**

I understand that my medication history may be obtained utilizing electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize South Bay Retina, Inc. to access my medication history as is required to process, retrieve or transmit electronic prescriptions.

**Pharmacy:** \_\_\_\_\_ **Street:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SOUTH BAY RETINA, INC.**  
**Keshav Narain, M.D.**

**PROTECTED HEALTH INFORMATION (HIPPA)**

I consent to the use and disclosure of my protected health information by South Bay Retina, Inc., Keshav Narain, M.D. and staff for the purposes of treatment, payment and health care operations only.

I give consent to South Bay Retina, Inc., Keshav Narain, M.D. and other providers involved in my care to use and/ or disclose my protected health information for the purposes of treatment payment, and health care operations. I understand health care operations may include, among others, uses or disclosures relative to quality review, utilization review, medical necessity, or legal review. Protected health information may include medical records, insurance and payment information, and other information used in whole or in part, to make decisions about me. South Bay Retina, Inc., Keshav Narain, M.D. and staff have provided me information about how my protected health information may be used and its purposes.

I acknowledge that I have read or been offered a copy of the Notice of Privacy Practices.  
Please list individuals who are involved with your care and who it is okay to share your health information with:

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The information that I have provided is current and accurate to the best of my knowledge. I understand that all information is used in the care and treatment of my condition. No information, medical or otherwise shall be used for commercial purposes or released to any party for purposes other than the care of your health.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*Complete this section only when someone other than the patient is signing on their behalf.

Patient's relationship to signer: _____	
<input type="checkbox"/> Patient is unable to sign or acknowledge	
<input type="checkbox"/> Patient refuses to sign but was given the opportunity to acknowledge and sign	
Signature: _____	Date: _____
Witness Signature: _____	Date: _____