**PLEASE PRINT CLEARLY**

**Patient Information** **Gloria Wu, M.D., Retina Society, F.A.A.O.**

Patient Name _____Date of birth_____ Age _____Last 4 digits SSN_____
Please circle: Gender M __ F__ Married ____ Single ____ Widow ___ Divorced __ Separated_____
Street Address: _____ City _____ Zip Code: _____
Home Phone No. _____ Cell Phone No. _____Work Phone No. _____
Email _____
Patient Employer _____ Occupation _____ How Long Employed _____
Spouse's Name _____Spouse Cell No. _____ Number of Children & Age_____
Person Responsible _____ Phone No. _____
Street Address _____ City _____ Zip Code _____
Emergency Contact _____ Phone No. _____ Relation _____

**Primary Insurance** Primary Care MD name & telephone_____
Name of Insurance Company _____
Type of Insurance (please circle): PPO EPO Covered California HMO
Name of Insured _____ Please circle: Self Spouse Parent Other
Last 4 Digits of SSN _____ Date of Birth of Insured _____

**Secondary Insurance**
Name of Insurance Company _____
Type of Insurance (please circle): PPO EPO Covered California HMO
Name of Insured _____ Please circle: Self Spouse Parent Other
Last 4 Digits of SSN _____ Date of Birth of Insured _____
Do you give us permission to communicate with **you, your other physicians**, and for **telemedicine/telehealth**?
Your eye images may be shared online and may not be protected during COVID-19 time.

Signature: _____ Date: _____

ALL CHARGES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED. THIS WILL ALLOW US TO CONTROL OUR COSTS AND TO KEEP FEES AT A REASONABLE LEVEL. THANK YOU FOR YOUR COOPERATION. Please keep in mind that the physician does not have a contract with the insurance company… You do. It is your responsibility to see that they pay on time. (Your eye images, deidentified, may be linked to national database to help your doctor figure out if you are normal for your age, gender, ethnicity, health condition: **Initial**____)

**Assignments of Medical Benefits**

I understand that I am financially responsible for all charges incurred for any treatment. I hereby authorize the doctor to release all information necessary to secure payment. I furthermore understand that should collection efforts be required to secure payment on my account, that I will be responsible for these additional fees as well.

I hereby assigned all medical/surgical insurance benefits to which I am entitled to the physician. These include, but are not limited to, major medical benefits to which I am entitled. This assignment shall remain in effect until rendered by me in writing. A photocopy of this assignment is to be considered valid and original. **YOU ARE RESPONSIBLE FOR YOUR ANNUAL DEDUCTIBLE AND OUT-OF-POCKET.**

**Non-Contracted Services**

I understand and agree that my health coverage involves an arrangement between my health plan and the physician. However, I understand that all services rendered to me are charged to me directedly and that I am personally responsible for payment at the time of services. I authorize that the above information is complete, current, and I have no other insurance. In case my doctor is not part of the health plan, I am responsible for the payment at the time of services.

Signed: _____ Date: _____

Patient or financially responsible party

# Gloria Wu, M.D., Retina Society, F.A.A.O.

Name: _____ Birthday: ___/___/_____ Date: ___/___/____

Primary Care Physician: _____ Height: _____ Weight: _____

Address: _____ Contact Number of Physician: _____

## Patient History

Have you ever had, or do you have… (Please circle and how many years have you had condition)

**Alcoholism**_____
**Anemia**_____
**Angina/Heart Attack**_____
**Arthritis**_____
**Asthma/Hay Fever**_____
**Autoimmune Disease**_____
**Birth Defects** _____
**Bladder Disease**_____
**Bleeding Disorder**_____
**Cancer**_____
What type: _____

**Retinal Detachment**_____
**Diabetes**_____
Type I / Type II / Other:_____
How long? _____
**Emphysema**_____
**Epilepsy** _____
**Glaucoma** _____
**Headaches** _____
**Heart Failure** _____
**High Blood Pressure** _____
How long: _____

**Kidney Disease** _____
**Liver Problem** _____
**Lung Problem** _____
**Mental Illness** _____
**Stroke** _____
**Thyroid Problem** _____
**Tuberculosis** _____
**Sexually Transmitted Diseases**_____

**Other**: _____

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Drug Allergies?

Current Medications?

Surgeries and Injuries?

**Lasik Surgery**
When? _____
Right eye / Left eye
**Eye Surgery**
**When?** _____
Right eye / Left eye
Laser Eye Surgery
**When?** _____
Right eye / Left eye

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## Family History

(Please circle and indicate which family members: Father, Mother, brother, sister, grandparents)

**Alcoholism**_____
**Anemia**_____
**Angina/Heart Attack**_____
**Arthritis**_____
**Asthma/Hay Fever**_____
**Autoimmune Disease**_____
**Birth Defects** _____
**Bladder Disease**_____
**Bleeding Disorder**_____
**Cancer**_____
What type: _____

**Retinal Detachment**_____
**Diabetes**_____
Type I / Type II / Other:_____
How long? _____
**Emphysema**_____
**Epilepsy** _____
**Glaucoma** _____
**Headaches** _____
**Heart Failure** _____
**High Blood Pressure** _____
How long: _____

**Kidney Disease** _____
**Liver Problem** _____
**Lung Problem** _____
**Mental Illness** _____
**Stroke** _____
**Thyroid Problem** _____
**Tuberculosis** _____
**Sexually Transmitted Diseases**_____

**Other**: _____

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## Social History

Do you… (Please circle)

**Exercise**
Type: _____
How often: _____

**Use Alcohol**
Beer / Wine / Liquor
How Often: _____

**Use Drugs**
Marijuana / Heroin
Cocaine/LSD/Crack

**Are you a…**
**Non-smoker**
**Current smoker**
**Former Smoker**
How often/long ago: _____

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Patient Review of Symptoms

**Have you ever experienced or are you experiencing any of the following:**
(Please circle all that apply and indicate **when** you experienced this)

**Vision:** floaters, eye pain, loss of vision, flashes of light, surgery, other — No Symptoms

**Head and Neck:** hay fever, masses, pain, surgery other — No Symptoms

**Heart:** heart attack, palpitations, chest pain, high blood pressure, shortness of breath, surgery, other — No Symptoms

**Lungs:** TB, wheezing, shortness of breath, need for oxygen tank, surgery, corona virus other — No Symptoms

**Stomach and colon:** reflux, ulcer, cancer, hepatitis, colitis, surgery, other — No Symptoms

**Urinary Tract**: urination problem at night, cancer, surgery, other — No Symptoms

**Muscle/Bones:** fractures, back pain, arthritis, joint pain, cancer, surgery, other — No Symptoms

**Skin/Hair:** bleeding, rashes, psoriasis, loss of hair, burns to skin, surgery, other — No Symptoms

**Neurological:** stroke, weakness, eyelid droop, numbness, double vision, dizziness, surgery, other — No Symptoms

**Mental health:** mood swings, situational stress, anxiety, depression, other — No symptoms

**Endocrine/Glands/thyroid:** hair loss, thyroid disease, diabetes, heat, cold, surgery, other — No Symptoms

**Ob/Gyn/Breast:** how many pregnancies, how many children, breast cancer, breast disease benign, surgery, other — No Symptoms

**Blood/Clotting disorders/Cancer:** bleeding easily, night sweats, cancer, surgery, chemotherapy, other — No Symptoms

**Allergy/ Immune status:** autoimmune disease, uveitis, iritis, asthma, surgery, other — No Symptoms

**Acknowledgement of Receipt of Notice of Privacy Practices**

Gloria Wu, M.D., Retina Society, F.A.A.O.
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Ophthalmology
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Gwu2550@gmail.com
408-356-5556

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practice upon my request.

Signed: _____ Date: _____

Printed Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

__ Parent or guardian of minor patient
__ Guardian or conservator of an incompetent patient
__ Beneficiary or personal representative of deceased patient

Name of Patient: _____

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## Definitions

**Co-Pay** (fixed amount paid to MD at the time of the visit): Determined by your insurance company as a way to get you to participate in costs of health care, concept that began in 1987.

**Co-Insurance** (percentage of costs covered after your deductible has been paid by you): Some insurance companies use this term. Not used by all insurance companies.

**Deductible** (the amount you pay for covered health care services before your insurance plan starts to pay.) With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. If you have a car accident, there is a $1,000 deductible. Similarly, this concept applies to health insurance when health insurance began in the US in 1960's.

Family plans often have both and individual "deductible," which applies to each person, and a family "deductible," which applies to all family members.

Generally, plans with lower monthly premiums have high deductibles. Plans with higher monthly premiums usually have lower deductibles.

Deductibles became very high in 2013 when the Affordable Care Act was created (Obamacare). Ranges from $2,000 to $6,000 per year per individual or per family.

**Out of Pocket Maximum** (The "maximum you have to pay for a year): Depends on your insurance company.

Our office has verified your eligibility and benefits. Per your insurance, you are subject to an out-of-pocket cost. If your "out-of-pocket" has not been met, you are responsible to pay a certain amount after your insurance has made the final determination.

I agree to the terms above and my signature acknowledges that I was told the definitions by the office staff or billing staff of Dr. Wu.

Patient Signature: _____ Date: _____