Patient's Name

First	Middle	Last

Address:			
Street & Apt #	**City**	**State**	**Zip**

SS # :	**Birthdate:**	**Age:**	**Sex:** ❑ Female ❑Male
Marital Status	❑ Single	❑ Married to:	❑ Other:
Home:	**Cell:**	**Other:**	
Preferred Contact: ❑Home ❑ Work ❑Cell ❑Email	**E-mail:**		
Any restrictions for contacting you?	❑No ❑ Yes	If yes, please describe	
Work Phone:	**Ext:**	**Is it okay to call you at work?**	❑ Yes ❑ No
Emergency Contact:	**Relationship to Patient:**	**Phone#:**	
Patient's Employer:	**Occupation:**		
How did you hear about us?	❑ Friend ❑ Insurance ❑ Internet ❑ Other	Details:	
Primary Dr.:	**Phone Number:**		

PHARMACY

Preferred Pharmacy:	**Phone:**
Address:	

INSURANCE INFORMATION

Primary Ins:	ID #:	Group #:	
Insured: Name:	DOB:	SS#:	
Relationship to the insured?	❑Self	❑Child	❑Spouse ❑Other
Secondary Ins:	ID #:	Group #:	
Insured: Name:	DOB:	SS#:	
Relationship to the insured?	❑Self	❑Child	❑Spouse ❑Other

VISION INSURANCE

Primary Ins:	ID #:	Group #:	
Insured name:	DOB:	SS# :	
Relationship to the insured?	❑Self	❑Child	❑Spouse ❑Other

X____ ________________________

Patient's Signature Date

Name: ,
Date: 1/21/2022
Date of Birth:

☐ **IF NO CHANGES PLEASE CHECK THE BOX, SIGN AND DATE (only if you've been seen within the last year)**

Who is your primary physician? ________________________ **Phone Number:** ____________________

List any medications you're currently take (Rx and over-the-counter): ______________________________

____

____

Do you have allergies to any medications? YES NO

If yes, list the medications: ____

List of any surgeries you have had: ____

____

Have you ever had a blood transfusion? YES NO If yes, when? ____________________

PLEASE CHECK BOX IF THE ANSWER IS YES TO ITEMS BELOW:

□ Cataracts □ Retinal Disorders □ Macular Degeneration
□ Glaucoma □ Diabetic Retinopathy □ Corneal Problems

FAMILY HISTORY: Please check box if the answer is yes and circle **M for maternal** or **P for paternal**

□ Cancer **M / P** □ Diabetes **M / P** □ Hypertension **M / P** □ Heart disorders **M / P**
□ Glaucoma **M / P** □ Retinal Disorders **M / P** □ Macular Degeneration **M / P**

PLEASE CHECK BOX IF YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS:

□ **Cardiovascular**
- □ Heart Attack
- □ Angina
- □ Stroke
- □ High blood pressure
- □ Pacemaker / Defibrillator

Other: ______________

□ **Neurologic / Psychiatric**
- □ Seizures / Convulsion
- □ Parkinson's disease
- □ Alzheimer's

Other: ______________

□ Ear / Nose / Throat

□ **Endocrine**
- □ Diabetes
- □ Thyroid

Other: ______________

□ **Hematologic**
- □ Anemia
- □ Bleed / bruise easy

Other: ______________

□ **Musculoskeletal**
- □ Arthritis
- □ Joint replacement

Other: ______________

□ **Stomach / intestinal**
- □ Ulcers
- □ Colitis

Other: ______________

□ **Respiratory**
- □ Asthma
- □ COPD
- □ Tuberculosis

Other: ______________

□ **Cancer** ______________

□ **Skin Problem** ______________

□ **Ocular Surface Disease**
- □ Itchy Eyes
- □ Red Eyes
- □ Watery Eyes
- □ Swollen Eyes
- □ Dry Eye
- □ Foreign Body Sensation

□ **Additional Allergy Symptoms**
- □ Asthma
- □ Congestion
- □ Runny Nose
- □ Dark circles under eyes
- □ Itchy/ flaky skin

SOCIAL HISTORY: Please answer the questions below

Do you drink alcohol? YES NO If yes, how much? ______________________________
Do you currently smoke? YES NO If yes, how much? ______________________________
Are you a former smoker? YES NO If yes, when did you start? ______________ Stop? ______________

Signature: ________________________________ Date: ____________________

Help us streamline your visit
By letting us know your concerns

Mosaddegh Eye Institute

Patient ID #
Patient Name:
Date of Birth: Age:

Optical:

Glasses
Contact Lenses

Vision Concerns:

Blurry Vision
Halos at night
Decreased Vision
Fluctuations in Vision
Flashes of Light
Eye Fatigue

Dry Eye Concerns:

Dryness
Eye Pain
Light Sensitivity
Foreign Body Sensation
Gritty Eyes
Sandy Sensation
Watery Eyes
Burning Sensation

Mosaddegh Aesthetics Institute

Aesthetics:

General facial assessment
Forehead Lines
Frown Lines
Crow's feet lines
Flattened Cheeks
Lines and wrinkles around nose and mouth
Lip appearance
Loose neck skin
Skin appearance

Check Out Initials: ____________

COVID-19 RISK INFORMED CONSENT

I (patient name) understand that I am opting for an eye exam/treatment/procedure/surgery that may not be urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Lillie Mosaddegh and all the staff at Mosaddegh Eye Institute is closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Lillie Mosaddegh and all the staff at Mosaddegh Eye Institute to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care Treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

PATIENT SIGNATURE_______________________________ DATE___________________

Check Out Initials: _____________