Efraim Duzman M.D.
Eran Duzman M.D.

New Patient Information

Name _____ DOB _____ Sex ____

Address _____ City _____

State ____ Zip _____ Phone # ( ) _____ Cell ( ) _____

SS# _____ Email Address _____

Marital Status _____ Person to contact in emergency _____

Relationship _____ Phone # ( ) _____

********** **Employer** **********

Name _____ Phone# ( ) _____

Address _____ City _____ Zip _____

********** **Insurance** **********

Insurance Company _____ Group # _____

Name of policy holder _____ Relationship _____

SS # of policy holder _____ Policy # _____

Name of 2nd Insurance _____ Group # _____

Name of policy holder _____ Relationship _____

SS # of policy holder _____ Policy # _____

********** **Other** **********

Primary care physician _____ Phone# _____

Who referred you _____

Signature of patient (or Guardian) _____ Date ____

Efraim Duzman M.D.
Eran Duzman M.D.

Medical history *(Page two, continuation from previous page)*

Yes No **Do you have any problem with your kidneys ?**

Yes No **Do you have any problems with your liver ? Did you have Jaundice or Hepatitis ?**

Yes No **Do you have any problems with blood clotting or a bleeding disorder ?**

Yes No **Are you subject to nervous disorders ?**

Yes No **Have you ever had psychiatric treatment ?**

Yes No **Have you ever been treated for alcohol or drug abuse ?**

.es No **Do you smoke ? if Yes how many cigarettes per day _____ ?**

Yes No **Have you been diagnosed as having positive HIV Test ?**

Yes No **Have you ever experienced a severe and unexpected reaction to a medical treatment ?**

If Yes , please specify _____

Yes No **WOMEN , Are you currently pregnant or planning to become pregnant ?**

If pregnant , how many months? _____ .

Yes No **Do you have any other condition disease or problem not listed above that you think we should know about ? If yes Explain :**

_____

I Confirm as true the above medical information . I Understand that this information is confidential and that it is being recorded to improve my medical care.

Signature : _____ **Date :** _____

Signature (office personnel): _____ **Date :** _____

Efraim Duzman M.D.
Eran Duzman M.D.

Medical & Health History

Patient Name _____ **Date** ___ / ___ / ___ **Age**_____

Chief complaint(S)_____

_____

Please answer each question by marking "yes" or "no"

Yes No **Are you in good general health?**

When was your last physical examination ? _____

Yes No **Has there been a change in your health within the past year ?**

Yes No **Are you now under the care of a physician?**

If yes please explain _____

Yes No **Have you been hospitalized or had a serious illness within the past five years ? Explain** _____

Yes No **Have you ever had any of the following medical condition (If yes, please Circle the condition**

Rheumatic Fever, Heart Murmur , Anemia , Epilepsy, Stroke , Diabetes, High Blood pressure, Thyroid condition, Kidney disease , Bleeding disorder Cancer, Others , (Please explain) _____

Yes No **Are you currently taking prescription medication? If Yes, please list.**

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6**_____

Yes No **Are you sensitive or allergic to any drugs ? If Yes , please list**

_____ _____ _____

Yes No **Do you have any lung disease or breathing difficulties ?**

Yes No **Do you have any heart trouble ? (Angina ? heart failure ? rhythm disorders?)**

Yes No **Do you have chest pain or cough on exertion ?**

Medical History Continued

Ophthalmic History

Have you ever experienced any of the following problems?

	NO	YES		NO	YES
Crossed Eyes	☐	☐	Glaucoma	☐	☐
Lazy Eye	☐	☐	Cataract	☐	☐
Eye Trauma	☐	☐	Retinal Disease	☐	☐
Other Eye Problems	☐	☐			

Please specify _____

If you answered YES to any of the above, please explain _____

_____

Are you currently using any eye medications? ☐ NO ☐ YES

If yes, please specify _____

Do you wear corrective glasses or contact lenses? ☐ NO ☐ YES

If yes, please specify _____

Have you had previous eye treatment or surgery? ☐ NO ☐ YES

If yes, please specify _____ Date _____

_____ Date _____

_____ Date _____

_____

I certify that the information furnished is true and correct.

Patient Signature _____ Date _____

Efraim Duzman, M.D. • 4605 Barranca Pkwy, Suite 100 • Irvine, California 92714 • (714) 733-2002

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the opthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Driving may be difficult immediately after an examination for some patients, you may elect to delay your driving after the appointment or return for dilation at a different time.

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. Duzman and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorize to sign for patient) Date

_____ _____

Witness Date

Efraim Duzman, MD
Eran Duzman, MD
A Profesional Corporation
Eye Physicians and Surgeons

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organiztion at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide on such restrictions.

Patient Name (print): _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so, as documented below.

Date:_____ **Initials:** _____ **Reason:**_____

Efraim Duzman, MD
Eran Duzman, MD
A Professional Corporation
4605 Barranca Parkway, Suite 100
Irvine, California 92604
(949) 733-2002 Fax (949) 733-1854

To All Patients,

We welcome you to our office. We thank you for entrusting us with your eye care. We can assure you that we will do the best we can to earn this trust and provide you with the best care. We are also committed to treat you professionally and cordially. Our office policy is not to turn away real emergencies. We are committed to give every scheduled patient as much time as needed to address her/his problem. This may occasionally cause unforeseeable delays to scheduled patients. We regret prolonged waiting time and are committed to reduce it. Our promises to you: whenever your turn comes, you can be assured you will be getting the time needed to address your problem. To be fair and effective in applying our time in the office, we have established the following procedures that apply to all our patients.

- In cases where a prescheduled appointment cannot be kept, it is the patient's responsibility to cancel at least 24 hours in advance. A $25 fee will be charged to patients that will fail to notify the office about an un-kept visit, and $100 fee for any un-kept appointment for an in-office surgical procedure.

- The doctors are available to answer phoned-in questions during working hours (8:00AM-6:00PM). A $50 fee will be charged to patients for after hour's consultations or prescription refills.

- When medically needed, the doctors routinely write a medical letter to your primary care doctor and/or to other specialist who participate in your care and to your health insurer. This is part of the medical practice and is not charged to you. For letters that are requested by patients and require review of medical records, there is a minimum of $100 charge. There is a minimum of $30 charge for filling out forms that require doctor's review and signature.

- Patients requesting copies of their medical records for their private use will be charged a minimum of $25.

- To save time and cost in our billing department, all co-payments are due at the time of the service. A $10 billing fee will be added to statements sent out to collect co-pays.

- A $25 delinquent payment and customary financial charges will be charged to the patient if due payments are not made within 90 days of the first billing. In cases where collection agencies are needed to collect overdue balances, the patient will be responsible for the cost that the agency will charge us.

- $25 will be charged for all checks returned unpaid.

I reviewed these policies and agree to accept them: _____
Patient/Guardian signature

Patient's name_____ Date_____

Patient Responsibilities

As a partner in your healthcare, you have the following responsibilities:

1. Please provide ***accurate and complete*** information concerning your present complaints, past medical history, and other matters relating to your health.

2. Please be sure that you ***clearly comprehend*** the course of your medical treatment and your responsibilities as a patient.

3. It will be ***beneficial*** to you to ***follow the treatment plan*** established by your physician. This includes instructions from nurses and other health care professionals as they attempt to carry out the physicians orders.

4. Please ensure that the ***financial obligations*** of your care are fulfilled in a timely manner.

5. If you need information or are inquiring about ***Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will)***, please call the Member Services Department of your Health Plan or the Patient Relations Department at Hoag Hospital.

6. We ask that you ***treat all providers, office personnel and other patients*** respectfully and courteously.

7. You need to ***communicate openly*** with your physician so that you can develop a personal patient-physician relationship.

8. You need to ***seek and obtain*** services on a consistent basis from your primary care physician. Remember that you should notify your physician immediately if your condition worsens.

9. You need to ***take charge*** of your health and make positive lifestyle decisions. For instance, watching what you eat, not smoking and getting regular exercise.

10. You need to consider the ***possible consequences*** if you refuse to follow the physician's orders or comply with the recommended treatment. In some cases, this could mean the transfer or disenrollment from the group.

11. Please keep your scheduled ***appointments*** or give adequate notice for delay or cancellation.

12. You need to ***read*** all Plan and education materials carefully so that you are aware of your benefits and their limitations. If you are unsure, please contact the Member Services Department of your Health Plan immediately.

13. You need to ***help*** your physician ***maintain*** accurate and current medical records by being open and honest when you provide information.

14. Please ***constructively express*** your opinions, concerns and complaints to the appropriate personnel within your Health Plan.

15. You need to notify your pharmacy when you change primary care physicians.

16. If you have ***lab tests, x-rays or pathology results pending***, please wait for ***a reasonable period of time*** before contacting the physicians office. In most cases, the physicians office will contact you directly.

I have been informed of my responsibilities and I understand them fully.

_____ _____

Patient's Signature *Date*

_____ _____

Witness *Date*