

A. M. Palanca-Capistrano M.D., Inc.
Diplomate, American Board of Ophthalmology
www.coronaeyedoctor.com

**720 Magnolia Ave, Suite A-4
Corona, CA. 92879**

**13800 Heacock St.
Suite C-110
Moreno Valley CA. 92553**

Please complete this form sign and return it to the receptionist. Thank you.

(Por Favor complete y firme la forma Gracias.)

Last Name (Apellido) _____ First Name (Nombre) _____ Middle Initial _____

Date of Birth _____ Age _____ SSN# _____

(Fecha de nacimiento) _____ (Edad) _____ (Numero de seguro social) _____

Address(Direccion) _____

City/State/Zip(Ciudad, Estado, Zona Postal) _____

Telephone Number (Telefono) _____ Work Phone (Telefono de trabajo) _____

Mark what applies below (cheque qué se aplica abajo)

Male (Hombre) _____ Female (Mujer) _____ Minor (Menor) _____

Single (Soltera) _____ Married (Casada) _____ Divorced (Divorciado) _____

Widowed (Viudo) _____ Separated (Separado) _____

Employer (Empleador) _____ Retired (Retirado) _____ Student (estudiante) _____

FOR BILLING YOUR INSURANCE INFORMATION (Informacion de Seguridad):

Medical Insurance/ID _____ Vision Insurance/ID _____

(Seguro Medico) _____ (Seguro Vision) _____

Name of Primary Insured _____ SSN# _____

(Nombre de asegurados primaries) _____ (Numero de seguro social) _____

Relationship to patient _____ Primary Insured Birth date _____

(relacion a la paciente) _____ (Fecha de nacimiento primaria de los asegurados) _____

Address(Direccion) _____

City/State/Zip(Ciudad, Estado, Zona Postal) _____

Primary Care Physician _____ Last Eye Doctor _____

(Medico de la atencion primaria) _____ (Doctor de ojo pasado) _____

Please specify below a friend or family member who we may share your medical information with:

Last Name (Apellido) _____ First Name (Nombre) _____ Middle Initial _____

Date of Birth _____ (Fecha de nacimiento) _____

Address(Direccion) _____

City/State/Zip(Ciudad, Estado, Zona Postal) _____

Telephone Number (Telefono) _____ Work/Cell (Telefono de trabajo) _____

Emergency Contact _____ Phone () _____

(Contacto de la emergencia) _____ (Telefono) _____

I authorize the release of information to process this claim and I authorize the release of payment to my physician Dr. Angelita P. Capistrano. I have read and will abide by the financial agreement and the privacy policies of the office and I certify that everything is true and correct. (Certifico todo estoy verdad y correcto).

Patient Signature: _____ Date: _____

How did you find out about our office? (Como le hizo para descubrir sobre nuestra oficina?)

Doctor _____ Optometrist _____ Insurance _____ Friend _____ ER _____ Other: _____

Medical History: Circle if you were ever diagnosed with the following and what date you had them.
(Medico Historial) (El circulo y fecha con un que doctor le ha diagnosticado)

Heart Attack _____ Stroke _____ Diabetes _____ how long (cuanto tiempo) _____
blood sugar level (nivel de azucar de sangre) _____

High blood pressure, Irregular heart beat, Asthma, COPD, Stroke, Cancer, Arthritis, Lupus, Marfans syndrome, Bleeding disorder, Thyroid problem, Kidney stones, Renal failure.

Surgical History: Have you ever had surgery? Atendido cirugia? (NO) or (YES)

If yes, what (si o no y cuando?) _____

Systemic Medications: Do you take any Medications (NO) or (YES) If yes: List Medications including herbal and non prescription medications: (Medicacion de la lista que usted esta tomando.)

List any medications you are allergic to: _____

(Que medicacion que usted sea alergico) _____

Ocular History: Do you wear eyeglasses or contact lenses. (Usa ahora antiojos y lentes de contacto)?
(No) (Yes). Have you been treated for any of the following eye diseases in the past? (No) (Yes) If yes circle them. (A sido tratado alguna enfermedad de los ojos si o no?)

Macular Degeneration, Cataracts, Glaucoma, Retinal detachment, Iritis, Uveitis, Cornea

Eye surgeries? (Cirugias del ojo?) (NO) (YES) If yes circle them. (circulo uno) Cataract, Retinal, Glaucoma, Muscle, Lid, refractive, Cornea _____

Eye Medications? (Esta usted usando medicaciones del ojo?) (NO) (YES) If yes list them. (Si enumerelos si): _____

Eye Injuries or Trama? (Liesiones del ojo o algun golpe? Si enumerelos si) (NO) (YES) If yes list them: _____

Social History? (Historia Social)

Do you smoke or chew tobacco YES / NO
(Usted fuma o mastica el tobacco)

How many cigarettes per day? _____
(Cuantos cigarettes por dia?)

Do you drink alcohol? YES / NO
(Usted bebe el alcohol?)

How much per day? _____
(Cuanto por dia?)

Do you use any illicit drugs? YES / NO
(Usted utilize cualquier droga ilicita ?)

Family History: Is there anyone in your family with the following diseases? (NO) (YES) If yes who?
(Hay cualquier persona en su familia con las enfermedades siguientes? Si si quien)

Diabetes, High blood pressure, Heart, Lung, Stroke, cancer, Marfans syndrome, Lupus, crossed eyes, Glaucoma, Macular Degeneration, Blindness, Color blindness _____

I authorize and request that payments under my insurance program be made directly to **A.M. Palanca-Capistrano, M.D. inc.** I also authorize **A.M. Palanca-Capistrano, M.D. inc.** to release information needed for the treatment, payment of claims and healthcare operations furnished to me or my dependent. I further permit copies of this authorization to be used in place of the original. I do realize that there will be a portion of the bill that is not covered by my medical insurance of which is my responsibility and I do agree to pay in full my obligation at the time/day services are rendered. I understand and agree, should my account be turned over to a collection agency, I will be responsible for the collection fees up to 50% of the outstanding balance. I also understand and agree to abide by the office arbitration policies and that should a suit be brought against me, I will pay court costs and attorney fees.

Patient Signature: _____ Date _____

Last Name (Apellido) _____ First Name (Nombre) _____ Middle Initial _____

Medical Review of Systems:

Do you currently have or you ever had any problems in the following areas. Circle your answer. (Hagale tienen actualmente o tenia nunca problemas en las areas siguientes. Circunde su respuesta.)

CONSTITUTIONAL

Fever, Weight loss / Gain	YES	NO
Cardiovascular	YES	NO
Arrhythmias	YES	NO
Cholesterol	YES	NO
Congestive Heart Failure	YES	NO
Coronary Artery Disease	YES	NO
Aneurysms	YES	NO

GASTROINTESTINAL

Ulcers	YES	NO
Bowel Disorders	YES	NO
Cancer	YES	NO
Diverticulitis	YES	NO
Reflux Disease	YES	NO

SKIN

Rosacea	YES	NO
Psoriasis	YES	NO
Skin Cancer	YES	NO

NEUROLOGICAL

Multiple Sclerosis	YES	NO
Alzheimer's	YES	NO
Muscular Dystrophy	YES	NO
Parkinson's	YES	NO
Stroke	YES	NO

PSYCHIATRIC

Pituitary	YES	NO
Thyroid	YES	NO
Diabetes	YES	NO

PSYCHIATRIC

Depression	YES	NO
Schizophrenia	YES	NO
Eating Disorder	YES	NO

EARS / NOSE / THROAT

Allergies	YES	NO
Sinusitis	YES	NO
Ear Infection	YES	NO

EYE

Blurry Vision	Yes	No
Double Vision	Yes	No
Light Sensitivity	Yes	No
Watery Eyes	Yes	No
Tired Eyes	Yes	No
Redness	Yes	No
Burning	Yes	No
Itching	Yes	No
Sand or Grit in Eye	Yes	No
Contact lens Discomfort	Yes	No
Fluctuation in Vision	Yes	No

RESPIRATORY

Emphysema	YES	NO
Bronchitis	YES	NO
Lung Cancer	YES	NO
Pneumonia	YES	NO

MUSCULOSKELETAL

Osteoporosis	YES	NO
Gout	YES	NO
TMJ	YES	NO

BLOOD / LYMPHATIC

Anemia	YES	NO
Leukemia	YES	NO
Lymphoma	YES	NO

GENITOURINARY

Drug Dependence	YES	NO
Alcoholism	YES	NO
Renal Failure	YES	NO
Urinary Tract Infection	YES	NO
Sexually Transmitted Disease	YES	NO
Nephritis	YES	NO
Panic Disorder	YES	NO

MMUNOLOGY

AIDS	YES	NO
HIV	YES	NO

I certify that everything is true and correct. (Certifico todo estoy verdad y correcto).

Patient Signature: _____ Date _____
 Last Name (Apellido) _____ First Name (Nombre) _____ Middle Initial _____