

**A. M. Palanca-Capistrano M.D., Inc.**  
**Diplomate, American Board of Ophthalmology**  
[www.coronaeyedoctor.com](http://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 Seguranza):

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? \_\_\_\_\_  
(Cuan to 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 \_\_\_\_\_