CATHERINE COX, M.D., 711 D Street, Suite 102, San Rafael, CA 94901

NEW PATIENT INFORMATION

Name _____ Date of Birth _____/_____/_____
Month Day Year

Street Address _____

City _____ State _____ Zip _____

Cell Phone (_____) _____ Other (_____) _____ ☐ Home ☐ Work

Email _____

Appointment reminders will be sent to your cell phone and/or email address. ☐ Do not want this service

Gender: ☐ Male ☐ Female ☐ Other _____

Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other _____

Emergency Contact _____ Relationship _____

Phone (_____) _____ ☐ Mobile ☐ Home ☐ Work

How did you hear about us? Referred by _____

If you are interested in cosmetic treatments and/or eyelid surgery, please explain:

_____

PHYSICIAN INFORMATION

Primary Care Physician _____ Location _____

Name _____ Specialty_____ Location _____

Name _____ Specialty_____ Location _____

MEDICAL INSURANCE

Please present to the front desk:

1) Insurance Cards **2) Photo I.D.** **3) Credit Card**

Payments: All estimated co-pays/deductibles/co-insurance will be collected prior to your exam or procedure; any outstanding balances will be charged to your credit card on file or invoiced.

Authorization to release: I hereby authorize Dr. Cox to furnish the insured's insurance company with all information requested to secure payment of benefits.

Assignment of insurance benefits: I hereby assign to Dr. Cox all monies to which I am entitled to expense, relative to the services rendered from time to time, but not to exceed my indebtedness to Dr. Cox. It is understood that any money received from the insurance companies over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to Dr. Cox for all charges whether or not they are covered by insurance.

Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov. I understand that Catherine Cox, M.D. is licensed and regulated by this medical board.

Your Signature _____ **Date** _____

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Name _____ Date _____

Preferred Pharmacy _____ **Location** _____

MEDICAL HISTORY

Are you currently or have you ever been treated for:

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Pressure - ☐ High ☐ Low
- ☐ Clotting & Bleeding Disorders*
- ☐ Diabetes
- ☐ Ear / Sinus
- ☐ Heart Condition*
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Gastro-intestinal problems
- ☐ Thyroid disorder - ☐ Hyper ☐ Hypo
- ☐ COPD / Emphysema / Bronchitis
- ☐ Musculoskeletal disorders
- ☐ Psychological/Psychiatric
- ☐ Serious Injury*

*Explain above or other serious condition(s) _____

Surgery Have you ever had surgery? Please list type of surgery and date:

	Date:
	Date:

☐ *Continued on back* ▸

Medications and/or Over-the-Counter Drugs Currently Taking

▸ **Do you take any NSAIDS or blood thinners** (i.e. aspirin, ibuprofen, coumadin, etc.)? ☐ **Yes** ☐ **No**

Name of Medication	Dosage	Reason

☐ *Continued on back or additional sheet attached* ▸

Allergies

Medication or Product	Reaction

☐ **No known allergies** ☐ *Continued on back* ▸

EYE HISTORY

Corrective Vision Information: ☐ Glasses ☐ Contact Lenses ☐ Refractive Surgery (i.e. LASIK)

Family history of eye problems? If yes, explain & relatives affected _____

I am currently experiencing or have been treated for:

- ☐ Blepharitis / Dry Eyes
- ☐ Blunt Eye or Eyelid Injury*
- ☐ Chalazion / Stye / Cyst
- ☐ Facial or Eyelid Spasms
- ☐ Glaucoma - ☐ Right ☐ Left
- ☐ Herpes simplex
- ☐ Skin Lesions
- ☐ Macular Degeneration - ☐ R ☐ L
- ☐ Watery Eye / Excess Tearing

*Explain above or other condition(s) _____

Eye / Eyelid Surgery Have you ever had ocular surgery? Please list type of surgery and date:

	Date:
	Date:

☐ *Continued on back* ▸

SOCIAL HISTORY

Do you consume alcohol? ☐ **Yes** ☐ **No** If yes, how often? _____

Do you smoke? ☐ **Yes** ☐ **No** **Have you ever consistently smoked in the past?** ☐ **Yes** ☐ **No**

Occupation _____ **Hobbies** _____

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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This office may use and disclose your health information for purposes of treatment, payment of services, help with public health care and safety issues, compliance with the law, law enforcement and other government requirements.

Our commitment to your privacy. Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. **Communications**. You can request that our practice communicate with you about your health and related issues in a specific way or at a certain location. For instance, you may ask that we contact you either at home or at work.
2. **Disclosures.** You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
3. **Health Information.** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Catherine Cox, M.D. The office manager may be reached by calling 415-578-0127.
4. **Corrections.** You may ask us to correct your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Catherine Cox, M.D. The office manager may be reached by calling 415-578-0127. You must provide us with a reason that supports your request for amendment. We may say "no" to your request, but will tell you why in writing.
5. **Right to a copy of this notice.** You are entitled to receive a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this document at any time. To obtain a copy, please see our front desk receptionist. It is also available on our web site www.bayeyemd.com.
6. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the U.S. Department of Health and Human Services, www.hhs.gov. To file a complaint with our practice, contact Catherine Cox, M.D. The office manager may be reached by calling 415-578-0127. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. We can change the terms of this notice, and the changes will apply to all information we have about you. Any new Notice of Privacy Practices will be available upon request in our office and on our web site, www.bayeyemd.com. For questions regarding this notice or our health information privacy policies contact Catherine Cox, M.D., or the office manager by calling 415-578-0127. Effective: 11/01/17

Open Payments Database: The Open Payments database (Database) is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov Effective: 01/01/23

Please sign and date below and return to front desk staff. This copy will remain with your chart.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND DATABASE: I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices and Database from Catherine Cox, M.D., Inc.

Print Name _____ **Signature** _____ **Date** _____

☐ **I would like a copy of this Notice of Privacy Practices and Database**