Kent W. Small, M.D.

Patient Information

The dilating drops used in your eyes as a part of the examination may blur your vision and make it unsafe to drive. Please attempt to drive when you are certain the effect of the medication has worn off, or arrange transportation. The effect of the drops usually last about 1-2 hours.

By initialing you agree to the above information. INITIAL: _____

PLEASE PRINT AND COMPLETE.

Name: Last Name First Name	Birth Date: Mon. Day Year	Sex: ☐ Female ☐ Male Social Security No.:
Address:	City	State/Zip Code
Primary Phone: ( ) -	Secondary Phone: ( ) -	Referred By:
Employer: Current Occupation: Are you retired? Yes No	Email Address:	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Other Contacts

Emergency Contact	Name:	Relationship:	Phone:
Responsible Party	Name	Relationship	Phone
	Address:	City:	State/Zip Code

Insurance Information

Please provide front office staff with insurance cards.

Primary	Company Name:	Type:	ID No.
	Insured Name	Relationship:	Group No.
Secondary	Company Name:	Type:	ID No.
	Insured Name	Relationship:	Group No.

Patient Privacy Information

I hearby authorize Dr. Kent Small and staff to communicate medical information pertaining to my care through the following methods: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

I hereby authorize Dr. Kent Small and staff to communicate medical information pertaining to my care to a referred or referring healthcare provider. I assume responsibility to notify the office should any of this information change in the future.

I acknowledge that the above information is true and correct.

Signature_____ Date:_____

Kent W. Small, M.D.

Office Policies

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES, AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE.

2. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT YOUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT UNLESS YOU ARE COVERED BY MEDICARE.

3. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED A ND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes that coordination or management of your health care with a third party. For example, we would disclose your protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training or medical students, licensing, and information to medical school students that see patients at our office. In addition, we may use a sing-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subjected to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. (310) 659-2200
Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

I hereby authorize Dr. Kent Small and staff to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

Kent W. Small, M.D.

Medical History

Name:_____

Referring Doctor:	Phone Number:	Fax Number:
Date of last eye exam:	Date of last eye photo/angiogram:	

Do you currently have any of the problems in the following areas? If "YES" please provide explanation below:

	YES	NO	Explanation of Problem
General Symptoms	☐	☐	_____
Fever	☐	☐	_____
Weight loss	☐	☐	_____
Cancer	☐	☐	_____
Eyes	☐	☐	_____
Loss/blurred vision	☐	☐	_____
Distorted vision	☐	☐	_____
Loss of side vision	☐	☐	_____
Lazy eye	☐	☐	_____
Ears, Nose, Mouth, Throat	☐	☐	_____
Impaired hearing	☐	☐	_____
Sinus infection	☐	☐	_____
Hay fever	☐	☐	_____
Cardiovascular	☐	☐	_____
Heart attack/chest pain	☐	☐	_____
High blood pressure	☐	☐	_____
Irregular heart beats	☐	☐	_____
Respiratory	☐	☐	_____
Wheezing/cough	☐	☐	_____
Shortness of breath	☐	☐	_____
Gastrointestinal	☐	☐	_____
Nausea/vomiting	☐	☐	_____
Ulcer/bleeding	☐	☐	_____
Genitourinary	☐	☐	_____
Incontinence/burning	☐	☐	_____
Frequency/bleeding	☐	☐	_____
Integumentary (skin, nails)	☐	☐	_____
Breast	☐	☐	_____
Neurological (stroke, tremors)	☐	☐	_____
Psychiatric (depression)	☐	☐	_____
Endocrine (diabetes, thyroid)	☐	☐	_____
Hematological / Lymphatic	☐	☐	_____
Anemia, leukemia	☐	☐	_____
Swollen lymph nodes	☐	☐	_____
Allergic/Immunologic/HIV	☐	☐	_____
Organ transplant	☐	☐	_____
OTHER (please explain)	☐	☐	_____

Kent W. Small M.D.

Name:_____

PHARMACY INFORMATION:

Preferred Pharmacy Name:	Address: City: Zip:	Phone No.: Fax No.:

PHYSICIAN INFORMATION:

Primary Care Doctor Name:	Address: City: Zip:	Phone No.: Fax No.:
Other Physicians Name and Specialty:	Address: City: Zip:	Phone No.: Fax No.:
Other Physicians Name and Specialty:	Address: City: Zip:	Phone No.: Fax No.:

MEDICATIONS

List current medications and dosages:	Allergies to medications, food, iodine latex, etc.? ☐Yes (please list) ☐No known allergies
List all major illnesses and injuries:	List any surgeries you have had:

FAMILY HISTORY

How many brothers do you have?_____How many sisters? _____
How many sons do you have?_____How many daughters?_____

DISEASE	YES	NO	Relationship to patient
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart attacks	☐	☐	_____

SOCIAL HISTORY

Do you drink alcohol? ☐YES ☐NO How often?_____
Do you smoke? ☐YES ☐NO How many packs a day?_____
Do you drive? ☐YES ☐NO
Have you ever had a blood transfusion? ☐YES ☐NO
History reviewed. ☐No changes ☐Additions as noted above

Physician's signature:_____Date:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE AND REQUEST TO:

DR. _____

ADDRESS: _____

_____

_____

PHONE: _____

FAX: _____

To release a copy of my complete medical records, photos, FA, Lab reports etc., in your possession, concerning my illness and/or treatment.

To: KENT W. SMALL, M.D.

☐ Cedars-Sinai Location
8635 W. 3rd St., Suite 395-W
Los Angeles, CA. 90048
Phone 310-659-2200,
Fax 310-659-2822

☐ Glendale Location
501 N. Orange Street Suite 250
Glendale, CA 91203
Phone 818-552-5040
Fax 818-552-5044

Patient Name:_____
Date of Birth:_____/_____/_____

SIGNED_____DATE:____/____/____

(Patient)