Kimberly Cockerham, MD, FACS
Neuro-Ophthalmology
Oculofacial Plastic Surgery
Eyelid & Orbital Oncology
Thyroid Eye Disease

## PATIENT INFORMATION:

| | | | | |
|---|---|---|---|---|
| Patient's Last name: | First: | Middle: | Marital status (check one) ☐ ☐ ☐ ☐ ☐ Single/ Mar /Div/ Sep/ Wid | |
| Street address: | | | Do you live alone? YES ☐ NO ☐ | |
| City: | State: | Zip Code: | D.O.B. / / | Sex: ☐ M ☐ F |
| Primary phone: Home / Cell ☐ ☐ | | Secondary phone: Home / Cell ☐ ☐ | | |
| Email: | | | Social Security #: - - | |
| Preferred Contact Method: ☐ Call ☐ Text ☐ Email | | | | |
| Primary Care Doctor: | | Phone/Address: | | |
| Referring Provider: | | Phone/Address: | | |
| Preferred Pharmacy: | | Address: | | |

## INSURANCE INFORMATION:

(Please give your insurance card to the receptionist)

| | |
|---|---|
| Primary Insurance: | Policy Number: |
| Subscriber's Name: | Subscriber's D.O.B: |
| Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other | |
| Secondary Insurance: | Policy Number: |
| Subscriber's Name: | Subscriber's D.O.B: |
| Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other | |

## IN CASE OF EMERGENCY:

| | |
|---|---|
| Name of local friend or relative: | Relationship to patient: |
| Primary phone: | |

The above information is true to the best of my knowledge. I authorize my insurance to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Perry Mansfield M.D. INC or insurance company to release any information required to process my claims.

______________________________ Patient/Guardian Signature

______________________________ Date

## SENTA EYE MEDICAL HISTORY QUESTIONNAIRE

DATE: ____________________

DATE OF BIRTH: ____________

NAME: ________________________________ HEIGHT: __________ WEIGHT: ___________

Primary Care Physician:____________________ Preferred Pharmacy:____________________________

Referring Physician:________________________ Location (street & city):__________________________

| DRUG ALLERGIES: | REACTION: | SEVERITY: |
|---|---|---|
| ______________________ | ____________________ | mild / moderate / severe |
| ______________________ | ____________________ | mild / moderate / severe |
| ______________________ | ____________________ | mild / moderate / severe |

____ NO KNOWN DRUG ALLERGIES

**PAST OCULAR HISTORY: (Please mark all that apply)**

| | | |
|---|---|---|
| __ Amblyopia (Lazy eye) | __ Aphakia | __ Cataracts |
| __ Diabetic Retinopathy | __ Dry Eyes | __ Glaucoma |
| __ Keratoconus | __ Macular Degeneration | __ Optic Neuritis |
| __ Retinal Detachment | Other ________________________________ | |

**OCULAR SURGERIES: (Please mark all that apply)**

| R – L | DATE | R – L | DATE | R – L | DATE |
|---|---|---|---|---|---|
| __ __ Foreign Body Removal | ______ | __ __ Punctal Plugs | ______ | __ __ Cataract Surgery | ______ |
| __ __ Blepharoplasty | ______ | __ __ Retinal Surgery | ______ | __ __ RK | ______ |
| __ __ LASIK | ______ | __ __ PRK | ______ | __ __ Strabismus | ______ |
| __ __ Corneal Transplant | ______ | Other Lasers ______________ | | Other Surgery ______________ | |

**CURRENT EYE MEDICATIONS: (Please list dose & frequency) Including over the counter**

______________________ ______________________ ______________________

______________________ ______________________ ______________________

**Are you taking Blood Thinners? (Please mark all that apply)**

| | | | |
|---|---|---|---|
| __ Aspirin 81 / 325 | __ Coumadin | __ Eliquis | __ Pradaxa |
| __ Lovenox | __ Xarelto | __ Motrin | __ Aleve |
| __ Advil | __ Naprosyn | __ Flax seed | __ Fish oil |
| __ Vitamin C | __ Vitamin E | __ Garlic Tablets | __ Turmeric |
| __ Ginkgo Biloba | Other ___________ | | |

**CURRENT EYE CONDITIONS: (Please mark all that apply)**

| | | |
|---|---|---|
| __ Blurred vison | __ Fluctuating vision | __ Loss of side vision |
| __ Double vision | __ Dryness | __ Glare/Light sensitivity/Halos |
| __ Mucous discharge | __ Redness | __ Eye trauma |
| __ Sandy/Gritty feeling | __ Itching | __ Burning |
| __ Distorted/Crooked vision | __ Tired/Fatigued eyes | __ Drooping eyelids |
| __ Flashing lights | __ Floaters | Other ________________ |

**ALL OTHER MEDICATIONS: (Please list dose strength and frequency)**

| ______________ | ______________ | ______________ |
|---|---|---|
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |

**OTHER MEDICAL HISTORY: (Please mark all that apply)**

__ Alzheimer's
__ Arthritis
__ Cancer Type: _________
__ Congestive Heart Failure
__ Dementia
__ Graves Disease
__ Herpes Simplex
__ High Cholesterol
__ HIV / AIDS
__ Liver Disease
__ Meningitis
__ Myasthenia Gravis
__ Polymyalgia
__ Skin Cancer
__ Thyroid Disease
__ Anemia
__ Asthma
__ COPD
__ Diabetes Type 1
__ Eczema
__ Headaches
__ Herpes Zoster/Shingles
__ Histoplasmosis
__ Kidney Disease
__ Lung Disease
__ Migraine
__ Multiple Sclerosis
__ Psychiatric Disorder
__ Syphilis
__ Wound Infection
__ Arrhythmia
__ Bleeding Disorder
__ Chicken Pox
__ Diabetes Type 2
__ Fibromyalgia
__ Hearing Loss
__ Hepatitis A / B / C
__ High Blood Pressure
__ Kidney Stones
__ Lupus
__ MRSA
__ Parkinson's
__ Stroke
__ Toxoplasmosis

Other ____________________________________________

**ALL PAST GENERAL SURGERIES/ OPERATIONS:**

| ______________ | ______________ | ______________ |
|---|---|---|
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |

**FAMILY HISTORY: (Check family association)** __ Unknown

| | Mother | Father | Brother | Sister | Grandparent |
|---|---|---|---|---|---|
| __ Blindness | ____ | ____ | ____ | ____ | ____ |
| __ Glaucoma | ____ | ____ | ____ | ____ | ____ |
| __ Macular Degeneration | ____ | ____ | ____ | ____ | ____ |
| __ Optic Neuropathy | ____ | ____ | ____ | ____ | ____ |
| __ Retinitis Pigmentosa | ____ | ____ | ____ | ____ | ____ |
| __ Cancer | ____ | ____ | ____ | ____ | ____ |
| __ Diabetes | ____ | ____ | ____ | ____ | ____ |
| __ Migraine/Headache | ____ | ____ | ____ | ____ | ____ |
| __ Stroke | ____ | ____ | ____ | ____ | ____ |
| __ Thyroid Disease | ____ | ____ | ____ | ____ | ____ |
| __ Tumor | ____ | ____ | ____ | ____ | ____ |
| __ Vertigo | ____ | ____ | ____ | ____ | ____ |

**SOCIAL HISTORY: (Please mark all that apply)**

Occupation: (if retired, former occupation) ______________________

Smoking:
- ___ Current daily smoker — How many packs a day ______________
- ___ Former smoker — Year you quit ______________
- ___ Vape Tobacco — How much a day ______________
- ___ Never smoked

Alcohol Use: ___ Yes ___ No — How often ______________

Recreational Drugs:
- ___ Current drug use — Drugs/Frequency ______________
- ___ Past drug use — Drugs/Frequency ______________
- ___ Never

**REVIEW OF SYSTEMS: (Please mark all that apply)**

Constitutional
- __ Fatigue / Weakness
- __ Fever
- __ Chills
- __ Sweats
- __ Weight Gain / Loss
- Other ___________

Cardiovascular
- __ Chest pain
- __ Irregular Heartbeat
- __ Fainting Spells
- __ Shortness of Breath
- __ Difficulty Lying Flat
- Other ___________

Hematology-Lymphatic
- __ Easy Bruising
- __ Prolonged Bleeding
- __ Jaundice
- __ Hepatitis
- __ Swollen Lymph Glands
- Other ___________

Musculoskeletal
- __ Stiffness
- __ Arthritis
- __ Joint Pain / Swelling
- __ Neck / Back Pain
- Other ___________

Psychiatric
- __ Anxiety / Depression
- __ Suicidal
- __ Hallucinations
- Other ___________

Head, Ear, Nose & Throat
- __ Decreased Hearing
- __ Ringing in Ears
- __ Sinus Pressure
- __ Nasal Congestion
- __ Runny Nose
- Other ___________

Gastrointestinal
- __ Heartburn
- __ Nausea / Vomiting
- __ Diarrhea
- __ Constipation
- Other ___________

Endocrine
- __ Increased Thirst
- __ Increased Hunger
- __ Increased Urination
- __ Increased Sweating
- __ Cold / Heat Intolerance
- Other ___________

Skin
- __ Rash / Sores
- __ Lesions
- __ Hives / Eczema
- __ Itching
- __ Abrasion
- __ Keloid Scar
- Other ___________

Respiratory
- __ Cough
- __ Congestion
- __ Wheezing
- __ Sleep Apnea
- Other ___________

Genito-Urinary
- __ Pain / Difficulty
- __ Blood in Urine
- __ History of Kidney stones
- __ History of STD's
- Other ___________

Immunologic
- __ Recurrent Infections
- __ Recurrent Fevers
- __ Immunocompromised
- __ Malaise
- Other ___________

Neurological
- __ Seizures
- __ Headache
- __ Vertigo
- __ Weakness / Paralysis
- __ Numbness
- __ Tremors
- __ Memory Difficulty
- __ Dizziness
- Other ___________

**Patient Signature:** ______________________ **Date:** ___________

## AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/ mental health conditions, or alcohol/ substance abuse have special rules that require specific authorization.

**AUTHORIZATION:** I hereby authorize: ______________________________
Physician/ Healthcare Facility Name

To release information on ____________________ (patient's name) ________ (DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and /or medical records including those from my other health care provider that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

**To: Kimberly Cockerham, MD, FACS**
**3590 Camino Del Rio N Ste 200**
**San Diego, CA 92108**

**Phone: 619-810-1275**
**Fax: 619-215-0404**

The medical information/ records will be used for the following purpose: ____________________

This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Illness, HIV Diagnosis/ Treatment)
[ ] Limited to the following medical information: ______________________________

I also consent to the specific release of the following records:
Drug/Alcohol/ Substance Abuse ________(initial)
HIV Diagnosis/ Treatment________(initial)
Psychiatric/ Mental Health ________(initial)
Genetic Information ________(initial)
Test for Antibodies to HIV ________(initial)
MRI/CT Imaging ______(initial)
Bloodwork ________(initial)

**DURATION:** This authorization shall be effective immediately and remain in effect until canceled in writing.

**RESTRICTIONS:** Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

______________________________
Signature of patient *or legal representative*

______________________________
Relationship *if other than patient*

______________________________
Patient's Name (PRINT)

______________________________
Date

MAILING ADDRESS

MISSION VALLEY
3590 Camino Del Rio N
Suite 200
San Diego, CA 92108
PH: 619-810-1275
FX: 619-215-0404

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# Patient Photograph Release Form

## Patient Information:

**Patient's Name:**______________________________ **Date of Birth:** ____________

**Photograph Consent and Release:**

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body, before and after surgery. The photographs will be taken by one of the members of Dr. Kimberly Cockerham's staff. Any photographs taken will become part of my medical records. My photographs are to be used for the purposes of insurance pre-authorization, office and hospital medical charts, and any necessary medical treatment. I hereby give my consent for Dr. Kimberly Cockerham to use the photographs under the following conditions:

***Please choose one of the following options and initial***

**(Please initial)** _______ I authorize my photographs to be used for the purposes of: Medical Seminars, website publication and/or office photo albums. All efforts will be made to ensure patient anonymity and confidentiality. No names or identifying references will be made in conjunction with published photographs.

**(Please initial)** _______ I authorize my photographs to be used only for my medical record, my surgery record and insurance purposes of my surgery with Dr. Kimberly Cockerham. I understand these photos will not be used on the office website or in any publications.

Patient's Signature: ______________________________________Date: ________________

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# Acknowledgment of Receipt of Notice of Privacy Practices
# Senta Clinic and Kimberly Cockerham, MD

**I hereby acknowledge that I received a copy of this Notice of Privacy Practice.**
**I further acknowledge that a copy of the current notice will be posted in the reception area.**

Signature: ______________________________ Date: ______________

Patients Name: __________________________ Date of Birth: ___________

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at

E-mail address: ________________________________________

**If not signed by patient, please indicate:**

Relationship:

- ☐ Parent of Guardian of minor patient
- ☐ Guardian or Conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Authorized Consenter's Signature: _______________________ Date: __________

Printed Name: ________________________________________

MAILING ADDRESS

MISSION VALLEY
3590 Camino Del Rio N
Suite 200
San Diego, CA 92108
PH: 619-810-1275
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Financial Policy

Your insurance plan is a contract between you and your insurance company. We cannot guarantee your benefits or eligibility with your insurance plan.

We will extend the benefit of filing the necessary paperwork and submit a claim for reimbursement to your insurance company for you.

Payment for non-covered services is expected at the time of the visit.

If your insurance company denies a claim, or a portion of a claim, they should provide an explanation to you, their policy holder. Denial or reduction of a claim does not relieve you of the financial obligation.

I have read the above and I understand and agree to the Senta Clinic Financial Policy. I authorize the release of any medical information necessary to process insurance claims and to comply with medical reviews and audits. I further authorize payment of my benefits to be made to Kimberly Cockerham, M.D. for services provided to me. I understand that the ultimate responsibility for payment of services remains mine.

________________________________________

Print Patient Name

________________________________________

Patient Signature Date

________________________________________

Staff Witness Date

MISSION VALLEY
3590 Camino Del Rio N
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The Open Payments 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.

Acknowledgement of Receipt of Open Payments Database Notice
SENTA Medical Clinic
Division of Neuro-Ophthalmology
3590 Camino Del Rio North, Suite 200
San Diego, CA 92108

I hereby acknowledge that I received a copy of the Open Payments Database Notice.

Signed_______________________________ Date__________________________

Print Name _________________________________ DOB____________________

MISSION VALLEY
3590 Camino Del Rio N
Suite 200
San Diego, CA 92108

PH: 619-810-1275
FX: 619-215-0404