

# DAVID G. SHULMAN, M.D., P.A.

---

DAVID G. SHULMAN, M.D.  
DIPLOMATE AMERICAN  
BOARD OF OPHTHALMOLOGY

FERNANDO TRUJILLO, M.D.  
DIPLOMATE AMERICAN  
BOARD OF OPHTHALMOLOGY

## HIPAA PATIENT QUESTIONNAIRE

- Please list the family members or other persons, if any, whom we may inform about your general medical condition, your diagnosis and any billing questions (including treatment, payment and healthcare operations). **(As a reminder these will be the only people we will be able to speak to or release any information to regarding your account.)**

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

- Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

- Please indicate if we may mail your appointment reminder/recall postcard via the mail?

YES \_\_\_\_\_ NO \_\_\_\_\_

- This form will remain in effect until you make any changes in writing.

---

PATIENT SIGNATURE

---

DATE

**DAVID G. SHULMAN, M.D., P.A.**  
**FERNANDO TRUJILLO, MD.**

**Patient Consent and Acknowledge of Receipt of privacy Notice**

I understand that as part of the provision of healthcare services, David G Shulman, M.D., P.A. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, and treatment, and any plans for future care or treatment.

I have been provided with a Notice of privacy that provides a more complete description of the uses and disclosures of certain health information. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information may for directory purposes. I have the right to request restrictions as to how my health information may be uses or disclosed to carry a treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, conducting or arranging for medical review, legal services, and auditing functions, etc) and the organization is not required to agree to the restrictions requested.

By signing this form, I consent to use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: Agree to any restriction in writing that I request on the use and disclosure of my Protected health information: and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health In formation, which have been previously agreed upon.

\_\_\_\_\_  
(Patient's Name printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's signature (or Guardian, if minor)

\_\_\_\_\_  
Social Security (for ID purposes only)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**DAVID G. SHULMAN, M.D.**  
**FERNANDO TRUJILLO, M.D.**  
**PATIENT INFORMATION**

**DATE:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Marital Status** S M D W

**Occupation/Student:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Work Status:** Full-time Part-time  
Unemployed

**Primary Insurance Company** (Attention Medicare patients-please state name as shown on Medicare card)

**Subscriber/Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Subscriber SSN:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

**Insured's ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

**Subscriber/Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Subscriber SSN:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

**Insured's ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Responsible Party Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

\_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Relation to patient:** \_\_\_\_\_

**Sex:** \_\_\_\_\_ **Marital Status** S M D W **Date of Birth:** \_\_\_\_\_

**Student:** Full-time Part-time N/A **School:** \_\_\_\_\_

**IN CASE OF EMERGENCY:** (Next of Kin – NOT LIVING WITH YOU!)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**OVER-->**

**PLEASE COMPLETE THE FOLLOWING:**

1. Describe your current eye problems:

---

---

2. When was your last eye examination?

---

3. Is there a family history of eye disease? (specify)

---

4. Current medical problems:

---

---

5. List medicines you are allergic to:

---

---

---

6. List current medications:

---

---

---

7. Frequency of use:     Alcohol\_\_\_\_\_ Tobacco\_\_\_\_\_

8. Your Family Doctor:

---

9. You were referred by:\_\_\_\_\_

**PLEASE SIGN BELOW:**

---

*David G. Shulman, M.D., P.A.*  
*Fernando Trujillo, M.D.*  
*Lara Dudek, M.D.*

**WAIVER OF LIABILITY**

Medicare/Medicaid/Other Insurance/No Medical-Vision coverage

**ASSIGNMENT AND RELEASE:**

By signing the Assignment and Release agreement, I am authorizing my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for my deductibles, co-insurance or procedures deemed as non-covered services. I also authorize the physician to release any information required to process my claim.

If you do not have Medical/Vision coverage or participate in a plan that we are not participating providers, you will be responsible for the charges incurred.

By refusing to sign this agreement, you will be responsible for all charges in full at the time of service.

Thank you for your cooperation.

**Date**

**Signature**

---

---

---

---

---

---

---

---

---

---

---

---

**David G. Shulman, M.D., P.A.**

**Fernando Trujillo, M.D.**

999 E. Basse Rd. Suite 127

San Antonio, TX 78209

(210) 821-6901

(210) 821-6941 Fax

**Release of Medical Records**

Date: \_\_\_\_\_

RE: \_\_\_\_\_

DOB: \_\_\_\_\_

To Whom It May Concern:

I hereby authorize, \_\_\_\_\_

(Physician/Facility)

to release all medical information concerning the care, condition and treatment of my case. The information is to be sent to the following:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Facsimile (210) 821-6941

\_\_\_\_\_

Patient Signature