EYE CARE OF SAN DIEGO

Please Print

Patient Name_____
Last **First** **Middle**

Address_____
Street **Apt #** **City** **State** **Zip**

Date of Birth_____Gender_____

Home Phone_____Cell Phone_____

Work Phone_____Social Security#_____

E-mail_____

Occupation_____Employer_____

Spouse's Name_____Phone_____

Referred By_____Phone_____

Primary Physician:

Name_____Phone#_____

Whom to Notify in Case of Emergency:

Name_____ Phone#_____

Relationship to Patient_____

Insurance: Please list all healthcare insurance companies which cover this patient:

Primary Insurance_____Policy#_____Insured_____

Secondary Insurance_____Policy#_____Insured_____

Medicare#_____Medi-cal#_____

PLEASE READ AND SIGN THE FOLLOWING:

I HEREBY AUTHORIZE EYE CARE OF SAN DIEGO TO FURNISH INFORMATION TO MY INSURANCE COMPANY CONCERNING MY PRESENT ILLNESS OR INJURY. I HEREBY ASSIGN EYE CARE OF SAN DIEGO ALL INSURANCE BENEFITS TO WHICH I AM ENTITLED FOR SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND/OR ALL FEES NOT COVERED BY MY INSURANCE PLAN.

Signature_____Date_____

MEDICAL HISTORY QUESTIONNAIRE

(Please answer ALL questions)

Name _____ Date _____

Date of **birth** _____ Date of **last eye examination** _____

Reason for today's visit _____

PERSONAL MEDICAL/OCULAR HISTORY (Check all that apply)

Cardiovascular: □ High Blood Pressure □ Heart Attack Other:_____

Endocrine: □ Diabetes: Year Diagnosed_____ □ Hyperthyroid □ Hypothyroid Other:_____

Gastrointestinal: □ Gastric Reflux Other:_____

Genitourinary: □ Enlarged Prostate Other:_____

Hematologic/Lymphatic: □ High Cholesterol □ Anemia Other:_____

Immunologic: □ Seasonal allergies □ Lupus □ Sjogren's Other:_____

Skin: □ Acne □ Skin Cancer: List type/location_____ Other:_____

Neurological: □ Stroke □ Multiple Sclerosis □ Concussion Other:_____

Musculoskeletal: □ Arthritis □ Fibromyalgia Other:_____

Psychiatric: □ Depression □ Anxiety □ Insomnia Other:_____

Respiratory: □ Asthma □ COPD □ Other:_____

Other medical conditions:_____

Surgeries: List **ANY** surgery you have had on your body:_____

Previous **EYE surgeries:** □ Cataract: □ right □ left □ PRK/Laser procedure: □ right □ left □ **NONE**

Other:_____ Date(s) _____

FAMILY HISTORY M=Mother F=Father S=Sister B=Brother GM=Grandmother GF=Grandfather

DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Macular degeneration			
Eye turn			
Cancer			
Diabetes			
Heart disease			
High blood pressure			
Other (ex. Thyroid, Arthritis) **Specify:**_____			

MEDICATIONS: List **ALL medications** you currently take (prescription, over the counter and **eye drops**):

_____

_____

_____

Have you ever taken Flomax? □ YES □ NO If YES, when?_____

Are you **allergic** to ANY medications? □ YES □ NO

If YES, list the medication(s) and reaction:_____

SOCIAL HISTORY

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Do you drive? □ YES □ NO Do you have visual difficulty when driving? □ YES □ NO

Do you currently wear contact lenses? □ YES □ NO If YES, how long_____

Do you currently wear glasses? □ YES □ NO If YES, how old is your current prescription?_____

Do you smoke? □ YES: □ daily □ some days □ NEVER □ Previous Smoker: When did you quit?_____

Do you drink alcohol? □ YES □ NO If YES: □ less than 1 per day □ 1-2 per day □ 3 or more per day

History of drug use? □ YES □ NO Have you ever had a blood transfusion? □ YES □ NO

Do you ***currently*** have any problems in the following areas? If **YES**, please provide information.

	YES	**NO**	**EXPLANATION OF PROBLEM**
Blurred vision			
Excess tearing/Watering			
Eye pain or soreness			
Redness			
Loss of vision / Loss of side vision			
Double vision / Diplopia			
Flashes & Floaters			
Weight loss (abnormal)			
Dry mouth			
Shortness of Breath			
Stiffness			
Headache			
Mucous discharge			
Distorted vision (halos)			
Sandy or gritty feeling / Dryness			
Itching			
Foreign body sensation			
Glare/light sensitivity			
Infection of eye or lid (blepharitis, stye)			
Crossed eyes, lazy eye			
Drooping eyelid			
Other (for example: glaucoma)			

EYE CARE OF SAN DIEGO

CONSENT FOR DILATING EYE DROPS

Dilating drops enlarge the pupils of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. The length of time that vision will be blurred and the degree of eyesight impairment varies from person to person. It is not possible for your ophthalmologist to predict how much or how long your vision will be affected.

Driving even in low light conditions may be difficult or impossible after an examination with dilating drops. If possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternative arrangements for transportation after your examination. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others. Also, we strongly suggest use of sunglasses to reduce your increased sensitivity to light while driving. If you do not have sunglasses with you we can provide them for you.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention. Symptoms may include severe eye pain, nausea and vomiting, redness, and sudden onset of visual disturbance.

I HEREBY AUTHORIZE EYE CARE OF SAN DIEGO TO ADMINISTER DILATING EYE DROPS DURING THE COURSE OF MY TREATMENT. I UNDERSTAND THAT THESE EYE DROPS ARE NECESSARY TO DIAGNOSE MY CONDITION. I FURTHER UNDERSTAND AND ACKNOWLEDGE THAT I HAVE BEEN WARNED OF THE POTENTIAL RISKS THAT DILATING EYE DROPS MAY HAVE ON MY ABILITY TO DRIVE AND WILL TAKE APPROPRIATE STEPS TO REDUCE THIS RISK BY NOT DRIVING IMMEDIATELY AFTER MY EYES HAVE BEEN DILATED OR BY WEARING SUNGLASSES WHILE DRIVING.

I CERTIFY THAT I HAVE READ THE ABOVE DILATING INFORMATION. BY SIGNING BELOW I AM AFFIRMING I HAVE ASKED ALL QUESTIONS THAT I M IGHT HAVE REGARDING DILATING EYE DROPS.

Patient Name _____

Date	Patient Initials	Dr. Initials	Date	Pt. Initials	Dr. Initials

EYE CARE OF SAN DIEGO

EYECARE OF SAN DIEGO FINANCIAL POLICY

1. **INSURANCE POLICIES**: As a courtesy, we will bill your primary and secondary insurance policies. However, you are ultimately responsible for payment of services not covered by your insurance plan. It is your responsibility to call and check with your insurance as to which services are covered.

2. **CO-PAYMENTS**: Co-pays are due at the time of check-in for your appointment. Our office accepts cash, personal checks, credit cards, and debit cards.

3. **MISSED APPOINTMENTS**: If you have to reschedule your appointment, please call us at least 24 hours before your appointment time. If you do not call us within that period, you may be subject to a **$50.00** fee for the missed appointment.

4. **INSURANCE DEDUCTIBLES**: If you have not met your deductible for your plan year, you are required to pay it at your appointment time. It is your responsibility to verify with your insurance whether or not you have met your deductible.

5. **INSURANCE CARDS**: Your insurance card and complete insurance information is required at time of each visit. New patients may not be seen without insurance verification.

6. **RETRO ACTIVE POLICY CHANGES**. Should your eligibility and/or benefits change due to retro-active policy changes, you will be responsible for the cost of all services provided at that time.

7. **OUT OF NETWORK**: Payment is due in full at the time of service if we do not have a contract with your insurance plan. As a courtesy to you, we will bill your insurance and they will remit payment to you directly.

By signing below, you agree that you understand and will abide by the above described financial policy. Thank you.

Print Name	Signature	Date
John E, Bokosky, M.D. **Neil T Choplin, M.D.** **Asa D Morton, M.D.**	**Robert Thomas, M.D.** **Philip M Taunton, O.D.** **Adriana Sanchez, O.D.**	**Marcelline Ciuffreda, O.D.** **Nickolet Boermans, O.D.**
3939 Third Ave, San Diego, CA 92103	700 W. El Norte Pkwy, Escondido, CA 92026	9834 Genesee Ave, Fourth Floor, Ste. 428, La Jolla, CA 92037

EYE CARE OF SAN DIEGO

REFRACTION POLICY

- The test that is performed to determine your eye glass prescription is called a **refraction.**

- A refraction is considered **a non-medical service**, and for that reason is **NOT** covered by most medical insurance carriers.

- Some health plans have supplemental vision care coverage; if so, the refraction may be covered under the vision plan of your health coverage.

- If a glasses prescription is given and you do not have vision care coverage, there will be a refraction charge of **$50.00** payable at the time of service.

Please be aware that a referral from your primary care physician does not guarantee coverage for a refraction.

Please call your insurance carrier to find out whether or not you have vision care coverage.

- We are providers for **Medical Eye Services** and **Vision Service Plan.**

- **MES** and **VSP** require you to bring the appropriate forms to your visit in order to cover your refraction. With these forms you may not be required to pay the extra charge for the refraction depending on your benefits plan.

We want your experience at our office to be pleasant. It is our goal to meet all of your medical and optical needs at the time of your visit. We strive to provide our patients with the best possible care in the most cost-effective manner.

Contact Lens Wearers: The above information may also apply to contact lens evaluations. Fitting fees will vary depending on the type of lens needed. Please ask the front desk for our contact lens fee schedule.

Signature _____ Date_____

EYE CARE OF SAN DIEGO

Acknowledgement of Receipt of Notice of Privacy Practices and Patient's Rights and Responsibilities

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I have also been offered a copy of the Patient's Rights and Responsibilities policy.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only:

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

HIPAA RELEASE FORM

In accordance with HIPAA laws we need your authorization to speak with anyone by you with regards to your personal medical information. In the area below, please complete the information to let Eye Care of San Diego know how you would like us to handle your private medical information.

I, _____, give Eye Care of San Diego permission to speak with the following people regarding my personal medical information.

Name	Relationship

□ Please check this box if you do not wish us to speak with anyone but you with regards to your personal medical information.

_____ _____

Patient Signature Date

EYE CARE OF SAN DIEGO

To Our Patients,

We are finding that we are experiencing more and more difficulties in our dealing with insurance companies. We want to take this opportunity to explain our relationship with your insurance company.

There are presently over 500 different insurance companies that provide medical benefits. We cannot possibly know every detail of your policy. We will try our best to assist you with billing and predetermination of benefits. We are not, however, responsible if your insurance company does not pay for any procedure.

It is your responsibility to read your benefits booklet. We do not receive these booklets and when we speak with a rep from your insurance company we only get a summary of benefits, not a guarantee of payment. Every insurance company has their own set of guidelines. If you do not understand your benefits, you can either check with your employee representative, or we will be happy to check for you. However, if your insurance company gives us misleading information, or refuses payment, we cannot be held responsible.

We will do all we can to assist you with your insurance benefits, but our responsibility here is to provide proper medical care for each individual.

Sincerely,

Eye Care of San Diego