FAMILY EYE HEALTH
Optometry Center

Karen Peschke, O.D.
Jennifer Chinn, O.D.

WELCOME TO OUR OFFICE

Patient Information

Last _____
First _____MI_____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Cell Phone _____
Date of Birth _____Age ____Sex M F
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's) Name _____
Spouse (or Parent's)Work _____
Email_____
What is the major purpose of this visit?_____
_____
Any problems with your current contact lenses or glasses?_____

NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
❑ Friend or relative Name:_____
❑ Another Doctor Referral: Name_____
If not referred, how did you choose our office?
❑ Insurance List
❑ Saw Sign/Building
❑ Yelp
❑ Google Search
❑ Yellow Pages
❑ Other _____

OFFICE POLICY:

You have 90 days following your Comprehensive Eye Exam to return for any glasses related follow- up visits at no charge. After 90 days, you will be charged $45 for a glasses refraction if there are any problems with your glasses. A Comprehensive Eye Examination is required after 6 months from your initial visit. The Glasses Prescription expires TWO YEARS from your last comprehensive eye exam.

The Contact Lens Evaluation is a separate service fee. The fee includes the trial lenses and 90 days of contact lens-related visits, in order to have the doctor check the contacts and ensure that you are not having any problems with the trial lenses. After 90 days, you will be charged $49 for a contact lens refit, and you will have an additional 90 days of contact-lens related follow up visits. A Comprehensive Eye Exam is required after 6 months from your initial visit. The Contact Lens prescription expires in ONE YEAR, after which you will be unable to order any contact lenses.

Insurance Information

Will you be using any Vision or Medical insurance coverage for your visit today? ❑ Yes ❑ No (Skip section)
Vision Insurance_____
Subscriber Name_____
Subscriber DOB_____Last 4 SSN:_____
Medical Insurance_____❑HMO ❑ PPO
Do you have a flex spending account that you would like to use today? ❑ Yes ❑ No

Lifestyle Questions

Do/Are you……(check box if your answer is yes)
❑..want information on Laser Vision Correction surgery?
❑..work at a computer? How many hours? _____/ day
❑..prefer a thinner, lighter lens?
❑..spend time outdoors? How much? ____Hours/week
❑..bothered with glare while driving at night?
❑..interested in the latest lens technology and would like to learn about the best lenses available?
❑..like the variety of having several frames?
❑..have family members in need of eye care?

Are you experiencing any of the following symptoms?
❑ Blurry Vision
❑ Burning
❑ Double Vision
❑ Flash of light
❑ Floaters/Spots
❑ Headaches
❑ Itchiness
❑ Grittiness
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Tearing
❑ Trouble seeing at night

Have you ever been diagnosed or treated for any of the following?
❑ Cataracts
❑ Corneal Abrasions
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Eye Injury; what /when?_____
❑ Eye Surgery/LASIK; what /when?_____
❑ Glaucoma
❑ Iritis/ Uveitis
❑ Lazy Eye
❑ Macular Degeneration
❑ Retinal Detachment
❑ Other eye disorders_____

OVER PLEASE →

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other illicit drugs or substances? ❑ Yes ❑ No
Do you have a medical marijuana card? ❑ Yes ❑ No
Women Only- Are you pregnant or nursing? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

❑ Allergies; What kind? _____
❑ Cardiovascular (Arteriosclerosis, Heart murmur)
❑ High Blood Pressure
❑ High Cholesterol
❑ Constitutional (Fevers, Fatigue, Cough)
❑ Head (Headaches, Sinusitis, Dry mouth)
❑ Endocrine (Thyroid, Kidney)
❑ Diabetes; Insulin/ Non-Insulin?_____
❑ Digestive (Acid Reflux, Cirrhosis, Colon/liver cancer)
❑ Genitourinary (Prostate, uterine, kidney stones)
❑ Blood/ Lymph (anemia, leukemia, sickle cell)
❑ Immunologic (AIDS, HIV, Herpes Simplex, Syphilis)
❑ Skin (Acne, Basal Cell, dry skin, Psoriasis)
❑ Muscle/Bone (Arthritis, Osteoporosis, Fibromyalgia)
❑ Neurological (Bell's Palsy, MS, Epilepsy)
❑ Psychological (Attn Deficit, Depression, Anxiety)
❑ Respiratory (Asthma, Bronchitis, lung disease)

Patient Eye History

Date of Last Eye Exam_____
Date of Last Dilation_____
By Whom?_____

GLASSES:
Do you currently wear glasses? ❑ Yes ❑ No

CONTACT LENSES:
Have you ever tried contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What brand?_____
Solutions used_____
Are you interest in being evaluated for contact lenses today?* ❑ Yes ❑ No

* The Contact Lens Evaluation is an additional service that includes your trial lens and contact-lens related follow up visits for 90 days. This service is sometimes covered by your insurance as a benefit in lieu of glasses. Our fees are $89 for a basic sphere lens; $115 for toric (<2.75), multi-focal, or monovision lens; $150 for high toric (=/>-2.75) lens; and $325 for keratoconus fits.

I have read and understand the contact lens evaluation fee:_____ (Patient/ parent initials)

Family Medical/Eye History (Check all that apply)

Cataracts ❑_____
Corneal Problems ❑_____
Glaucoma ❑_____
Macular Degeneration ❑_____
Retinal Problems ❑_____
Diabetes ❑_____
Heart Disease ❑_____
Other ❑_____

Advance Beneficiary Notice

Please be advised that if you are using insurance coverage for today's visit, this is a contract between you and your insurance company. If your insurance company has not reimbursed our office in full within 90 days, you will be billed for today's visit and your insurance company may then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.

In the event that you are billed for your services and you do not make a reasonable effort to make payments, your account will be turned over to a collection agency. You would then be responsible for the full amount of your invoice from Family Eye Health Optometry Center, plus any fees incurred in the collection process.

Signature X_____Date_____

Acknowledgement of Receipt of Notice of Privacy Policies

Please be advised that a copy of our HIPPA policy is posted in our office, and is available by photocopy to all our patients. Please ask our staff if you would like a copy of our Privacy Policy today.

I acknowledge that I have been made available a copy of Family Eye Health Optometry Center Notice of Privacy Practice.

Signature X _____**Date**_____