Patient Check-In Forms and Instructions:
PLEASE READ BEFORE PROCEEDING

Thank you for choosing to fill out paperwork prior to your appointment. Doing so will allow us to serve you more efficiently, making your appointment faster and safer for you and our staff.

Please print and fill out the following forms, then bring them with you to your appointment. It is not necessary to total up the scores of your assessment forms, our staff will complete this step for you. Only patients ages 6 to 21 will need to compete the final page of this packet (Vision Therapy Assessment Form).

Please also bring any current medications and prescription eyewear (glasses or contacts) that you have available to your appointment.

If you have any questions, feel free to contact us at (916) 726-1818.

Thank you again for your cooperation. We look forward to seeing you at your appointment.

COVID19 - Patient Check in

Patient Name:_______________________________________

I confirm that I am not currently presenting or have had in the past 10 days any of the following symptoms of COVID19 listed below:

- Fever
- Shortness of breath
- Dry Cough
- Runny Nose
- Sore Throat

_________(Initials)

I verify that I have not traveled outside the US in the past 10 days _________(Initials)

I verify that I have not been in contact with anyone known to be infected with COVID19 in the past 10 days _________(Initials)

I understand that a face mask or facial covering is required for my office visit today _________(Initials)

I knowingly and willingly consent to examination and/or treatment by Eyecenter Optometric during the COVID19 Pandemic.

_______________________________________ _________________________

Patient Signature Date

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FOR OFFICE USE ONLY:

Temperature at check in:__________________ Taken by:_____________________________

Name:____ **Date of Birth:**____________________

Current mailing address: ____

Please let us know how you would like to be contacted.

□ Text message: Cell (________)________________________ □ Telephone: Home (_____) ______________________

□ Email address: ____________________________________ □ Postal

Preferred Language	Race	Ethnicity
___ English	___ American Indian or Alaska Native	___ Hispanic or Latino
___ Spanish	___ Asian	___ Not Hispanic or Latino
___ Russian	___ Black or African American	___ Decline to specify
___ Other	___ White	
___ Decline to specify	___ Decline to specify	

Billing: I request payment of authorized benefits by my insurance plan to be paid directly to EYEcenter Optometric, on my behalf, for services furnished to me by EYEcenter Optometric and request that they submit claims for payment for those services on my behalf to my insurance carrier(s). If my insurance does not pay, I understand that I am responsible for payment in full. My signature below is verification that I understand this agreement.

_________ **(Initials) I understand the above and agree to pay as appropriate.**

Retinal Imaging: Retinal imaging consists of the Optos Widefield Scanning and Retinal Health Assessment which allows the doctor to detect possible eye health diseases such as macular degeneration, glaucoma, diabetic retinopathy and cataracts. It is strongly recommended by our doctors to have the retinal imaging performed to detect such diseases since they begin in the deepest layers of the retina. The retinal imaging fee of **$45** is not typically covered by vision or medical insurance. However, some insurances extend a discount. Should you choose to decline the retinal imaging, dilation will be performed and is covered by vision and medical insurance.

________ **(Initials) I understand the above and agree to pay as appropriate.**

________ **(Initials) I decline the retinal imaging and agree to be dilated.**

Contact Lens Diagnostic and Fitting Fee: A contact lens diagnostic fee of **$80** renews your contact lenses prescription and is valid for one year. This fee is for existing contact lens wearers and is issued even when the type of lens and prescription does not change. A fitting fee of **$100-$500** is for patients that are new to contact lenses or are fit into a new type of lens or material. The diagnostic and fitting fee both include the following tests: Advanced Digital Health, Eyelid Health, Front of Eye Health and Tear Film. These tests allow the doctor to digitally visualize the cornea. The fee of $80-$500 also includes any trial contact lenses, follow up appointments with the doctor within 90 days of exam and a contact lens training if necessary.

_______ **(Initials) I understand the above and agree to pay as appropriate.**

_______ **(Initials) I decline the above and understand that I will not receive a prescription for contact lenses.**

Refraction: The refraction is a procedure when your corrective prescription for eyeglasses is determined by the doctor. The refraction is covered by most vision insurances. However, the refraction is not covered by most medical insurances. The refraction fee is **$78**, if payment is made the day of service, there is a 50% discount.

_______ **(Initials) I understand the above and agree to pay as appropriate.**

_______ **(Initials) I decline the refraction and understand that I will not receive a prescription for eyeglasses.**

I authorize EYEcenter Optometric to release my eyewear (glasses or contacts) and/or protected health information, including authorization to discuss account balances and details, with the following persons:

Name of Person:	Relationship	Date Authorized	Patient Initials
______________________	________________	_______________	_________________

Privacy Policy Statement

I have been provided with a copy of the NOTICE OF PRIVACY POLICY v2019.04.01 which provides a more complete description of information uses and disclosures of my medical records. I also understand that EYEcenter Optometric uses an automated communication system to send out notification and reminders as well as education material to our patient base. This communication system keeps all patient information confidential and does not distribute any private information.

____ ________________________________

Signature **Date**

EYEcenter
OPTOMETRIC

SPEED II Questionnaire

Name: ______________________________ **Date:** ____ /____ /____

Date of Birth: ____ /____ /____ **Sex:** **M** **F** **(circle)**

Dry eye disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering from this condition as well. Therefore, we ask that you take a few moments to thoughtfully complete the questionnaire below.

Report the **FREQUENCY** of dry eye symptoms you are experiencing by checking **NEVER**, **SOMETIMES**, **OFTEN**, or **CONSTANT** using the numbering system below:

0 = Never 1 = Sometimes 2 = Often 3 = Constant

SYMPTOMS	0	1	2	3
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Report the **SEVERITY** of your symptoms using the ratings below:

0 = No Problems
1 = Tolerable – not perfect, but not uncomfortable
2 = Uncomfortable – irritating, but does not interfere with my day
3 = Bothersome – irritating and interferes with my day
4 = Intolerable – unable to perform my daily tasks

SYMPTOMS	0	1	2	3	4
Dryness, Grittiness, or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Please mark with an "X" if you have experienced these symptoms:

1) Today ______ 2) Within the past 72 hours ______ 3) Within the past 3 months _______

Do you use eye drops and/or ointment? YES NO (circle)
If yes, which drops do you use?

Have you been told that you have blepharitis or have been treated for a stye?

Blepharitis YES NO (circle)
Style YES NO (circle)

Do you have fluctuating vision problems? (That can be corrected with blinking)
Circle: Never Sometimes Frequently A lot / Always

For office use only: Dry eye protocol (please circle one)

Level 1	Level 2	Level 3	Level 4
Speed Score 6-8	Speed Score 9-12	Speed Score 13-18	Speed Score >20

RFF SEG PNL JCC BC LBR JYL LL KT HKM

EYEcenter OPTOMETRIC

For patients under 21 yrs old

Vision Therapy Vision Assessment Form

Name: Date:

Do you play sports? Y N If yes, what sport and position?

Patient instructions: Please answer the following questions about how your eyes feel when reading or doing close work.

		Never	Infrequently (not very often)	Sometimes	Fairly Often	Always
1	Do your eyes feel tired when reading or doing close work?					
2	Do your eyes feel uncomfortable when reading or doing close work?					
3	Do you have headaches when reading or doing close work?					
4	Do you feel sleepy when reading or doing close work?					
5	Do you lose concentration when reading or doing close work?					
6	Do you have trouble remembering what you have read?					
7	Do you have double vision when reading or doing close work?					
8	Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?					
9	Do you feel like you read slowly?					
10	Do your eyes ever hurt when reading or doing close work?					
11	Do your eyes ever feel sore when reading or doing close work?					
12	Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13	Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14	Do you lose your place while reading or doing close work?					
15	Do you have to re-read the same line of words when reading?					
		(x 0)	(x1)	(x2)	(x3)	(x4)

Total Score:__________

Office Use Only
VT Assessment Scheduled? Yes No
Notes: