Dr. Jan & Eye Associates - Optometrists

PATIENT INFORMATION

Last Name	First Name	M.I.	(circle one) Male/Female	Birthdate / /	Age

Mailing Address	City	State	Zip Code	Home Phone

Cell Phone	E-Mail	Occupation/Employer

Referred By	Vision Insurance (circle one) VSP / Spectera / Davis	Insurance ID

RESPONSIBLE PERSON INFORMATION (if the patient is a minor or for insurance purposes)

Last Name	First Name	Birthdate	Relation to Patient

Medical History Questionnaire

Medical History

What is your general health? _____ Weight_____ Height_____

Do you or any family members currently or ever had any problems in the following systems? (Please circle yes or no)

Gastrointestinal	Yes / No	Nervous	Yes / No	Endocrine (glands)	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/Lymph	Yes / No
Cardiovascular	Yes / No	Muscles/Bone	Yes / No	Allergic/Immunologic	Yes / No
Respiratory	Yes / No	Headache	Yes / No	Integumerntary (Skin)	Yes / No
High Blood Pressure	Yes / No	Eyes	Yes / No	Mental	Yes / No

If yes, please explain:_____

Are you pregnant? Yes / No Are you breastfeeding? Yes / No

Diabetes Yes / No Type_____ Date of diagnosis:_____

Other health problems:_____

Do you or have you ever smoked? Yes / No If yes, how often?_____

Do you have any allergies to medication? Yes / No If yes, explain:_____

Current prescription, eye drops, or over the counter medication(s):_____

_____

List all major injuries, surgeries and/or hospitalizations: _____

Do you have any eye conditions or problems Yes / No What kind?_____

Do you or any family members currently or ever had any of the following:

Glaucoma	Yes / No	Cataracts	Yes / No	Color Blind	Yes / No
Macular Degeneration	Yes / No	Retinal Detachment	Yes / No	Crossed/Lazy Eyes	Yes / No

If yes, please explain and relation:_____

Do you wear glasses? Yes / No If yes, how old is your present pair of glasses? _____

Do you wear contact lenses? Yes / No Brand_____ How often do you replaces your lenses?_____

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PLEASE CHECK THE TYPE OF EXAM YOU ARE INTERESTED IN TODAY

_____ Routine Eye Exam (includes glasses prescription)	$60
_____ Dilation and Retinal Photos (recommended yearly)	$30
_____ Spherical Contacts (includes glasses prescription)	$99
_____ Astigmatism Contacts (includes glasses prescription)	$119
_____ Multifocal/Bifocal/Monovision/Hard contacts (includes glasses prescription)	$139
_____ Medical Level 1 (Pink/red/itchy/dry/floaters/flashes)	$60
_____ Medical Level 2 (Medical Level 1 with Dilation)	$75
_____ Contact Lens Class (Required 1st time contact lens wearers)	$20

All exams will include testing for eye muscles function, binocularity, cataract, glaucoma, macular degeneration, a copy of your glasses/contacts prescription for 1 year, and 2 months of follow up visits.

Upon request, we will give you an itemized invoice that you can submit to your medical or vision insurance for reimbursement. You are responsible for your insurance information and our office cannot file after the exam has been completed.

We accept Cash, Visa, Discover, Mastercard, and Checks. **Payment rendered at time of service, no refunds.**

We are affiliates with VSP, DAVIS, and SPECTERA vision plans as a benefit to our patients. Because our office is inside a Costco, our **office is not "IN NETWORK"**. You may receive a greater reimbursement by submitting on your own.
My signature below signifies that I acknowledge and accept the terms above.

Signature of Patient: _____Date:_____

Parent/guardian signature (if minor):_____

PUPILLARY DILATION CONSENT

Our office routinely dilates every patient to achieve the most comprehensive evaluation of the health of your eyes. Whether pupil dilation is necessary for every eye exam depends on the reason for your eye exam, your overall health and your risk of eye diseases.
Dilating the pupils may cause temporary blurring of your vision. We advise that you exercise caution in operating any equipment or machinery, including driving, until the effects have worn off.

Please check one of the following:
□ I would like my eyes dilating today if the doctor believes it is necessary
□ I do not want my eyes dilated (see below)

In refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

Signature of Patient: _____Date:_____

Parent/guardian signature (if minor):_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically.

I have received Dr Jan Eye Care Privacy Practice Notice.

Signature of Patient :_____Date:_____

Parent/guardian signature (if minor):_____