FAMILY EYE
CENTER OPTOMETRY

Dear Patient,

Welcome to Family Eye Center Optometry, *where we do things differently*. We want to thank you for choosing us for your eye health care. We value your confidence in us and want to let you know what to expect on your upcoming visit. This will insure a more comfortable and efficient visit for you.

- A comprehensive eye health examination and visual analysis will be performed to determine the state of your eyes and investigate any signs of disease or other eye health problems that may not have visible symptoms.

- We strive to spend quality time with each and every patient, and proper communication insures us this ability. If it is necessary to reschedule your reservation for any reason, please give us a call as soon as possible at (650) 654-2015 and we would be happy to do this for you.

- At The Family Eye Center Optometry, we are proud to announce the inclusion of retinal imaging as an integral part of your eye exam. Dr. Kagan highly recommends this part of the exam for all patients. This technology does not require pupil dilation. **We will be performing the retinal examination as an enhancement to the comprehensive exam for additional fee. If you choose to not employ this technology, your exam will include pupil dilation.** I feel you'll be very impressed with this technology, and these are the reasons I highly recommend this additional test;

  * Retinal imaging assists the doctor in the early detection of many disorders, including cataracts, glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and numerous other vision threatening conditions.

  * Remember that most vision and insurance plans only cover *basic or routine testing* and does not include this important procedure to insure the health of your eyes for many years to come.

- We have an excellent selection of eyewear frames, which includes some of the hottest name brands, from Ray-Ban, Oakley, Etnia of Barcelona, Fendi, Salvatore Ferragamo, Paul Frank, Paul Smith, Kate Spade, Liz Claiborne, Flexon, Airlock, TOMS and many more. You are encouraged to arrive early to have one of our opticians help you select the right frames for you. We take into consideration the many aspects of your lifestyle when helping you choose your eyewear, and remember that all of our fine eyewear frames come with our exclusive 2-year warranty.

  If you are a contact lens wearer or are interested in wearing them, we will include a Corneal Evaluation along with your examination. **The additional evaluation fee also includes diagnostic starter lenses, contact lens insertion and removal training and necessary follow-up care**. We will thoroughly investigate the best contact lenses for you and your life-style while backing it up with our 'Buy-em-Back' policy. If you currently wear contact lenses, we will perform an evaluation of your current contact lenses. Please bring the current specifications (located on your contact lens boxes).

- We ask that you please bring in all of the eyeglasses and sunglasses that you currently wear so the prescriptions can be verified. This will help Dr. Kagan determine how your eyes are changing.

Other items of importance to bring are a list of current medications and current insurance cards. Because benefits sometimes change, if you are not 100% sure with how your insurance company currently works their coverage and co-payments, please utilize the following insurance information including websites and telephone numbers to become more familiar. Some insurance companies request that you contact them ahead of time to become pre-authorized, so please insure this is done before your visit.
Here is a list of insurance companies that we are currently providers for:

VSP	800-877-7195	www.vsp.com
Eyemed	888-581-3648	www.eyemed.com
MES	800-877-6372	www.mesvision.com
Safeguard	855-638-3931	www.metlife.com
Blueview	866-723-0515	www.anthem.com
United Healthcare Vision	888-545-5205	www.myuhcvision.com
Visioncare direct	602-448-8177	www.visioncaredirect.com
Spectera	800-638-3120	www.spectera.com
Davis Vision	800-999-5431	www.davisvision.com
Blue Cross	866-249-4844	www.anthem.com
Blue Shield	800-393-6130	www.blueshieldca.com
Tricare	877-874-2273	www.tricare.mil
United Healthcare	866-633-2446	www.uhc.com
Cigna	800-997-1654	www.cigna.com
Aetna	800-872-3862	www.aetna.com

If your insurance company is not on our list, we will be happy to provide you with a detailed list of services that you can submit to your insurance company. Payment will be expected in full and your insurance company will reimburse you directly.

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In order for us to provide the best possible office experience, **please *complete* the enclosed 'Welcome' medical information form, and bring it with you to our office**. This diagnostic information helps Dr. Kagan determine your specific needs and aids in developing your treatment plan and recommendations year after year.

Please plan on arriving approximately 20 minutes ahead of schedule, as there are tests that the staff of Dr. Kagan will need to perform *before* your appointment time with Dr. Kagan.

Once again, thank you for choosing The Family Eye Center Optometry for your eye care needs. We look forward to seeing you soon.

Sincerely,

Dr. Alina Kagan

Family Eye Center Optometry 1601 El Camino Real, suite 302 Belmont, CA 94002 (650) 654-2015

PATIENT REGISTRATION & MEDICAL HISTORY FORM

First Name: ______________________ Last Name: ______________________________________ Middle Initial: _____ Preferred Name: ______________

Birth Date: ______________________ Social Security Number: ______________________ Insured's Name: ___________________________ Sex: **M / F**

Home Address: ____ Zip: __________ City: __________________ State: _______

Which phone number would you prefer we use to contact you? **Home** **Work** **Cell** Home Phone: _________________ Work Phone: _______________

Cell Phone: __________________________ Pager: ______________________________ E-mail address: ____

Marital Status: **Single** **Married** **Other** Referred by: ______________________ ***We must have a copy of all insurance cards on the day of service**

Primary Medical Insurance: ____ Secondary Medical Insurance: __________________________________

Vision Insurance: ____ Insured Social Security Number: _________________________________

Insured's Birth Date:____ Insured's Employer: ____

Family Doctor: ____ Family Dr. Clinic/Phone: ______________________________________

Family Members: ____For ease of data transfer, are they patients at this office? **Y / N**

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of (Your practice name here) statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize (Your practice name here) to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize (Your practice name here) to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date

SIGNATURE: ____ DATE: ____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

Loss of vision	**Floaters**	**Eye pain/soreness**	**Glare**	**Dry eyes**
Blurred vision	**Crossed eyes**	**Watery eyes**	**Light sensitivity**	**Red eyes**
Double vision	**Flashes of light**	**Sandy/gritty feeling**	**Tired eyes**	**Burning/itching**

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* **Right** **Left** **Both**
Quality *How is it effecting you?* **Bothersome** **Aware** **Painful**
Severity *How severe is the problem?* **Mild** **Moderate** **Severe**
Duration *How long have you had the problem?* ______________________

Timing *Is it new, ongoing, returning?* **New** **Ongoing** **Returning**
Context *Associated w/:* **Infection** **Medical condition** **Injury** **Surgery**
Modifiers *Previous treatment?* **Drops** **Medication** **Other:** _________
Symptoms *Are there associated symptoms?* **Headache** **Other:** _________

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):
No problems **Diabetes** **High blood pressure** **Cancer**

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):
No problems **Glaucoma** **Amblyopia** **Cataracts** **Macular degeneration** **Strabismus (eye turn)**

SOCIAL HISTORY

Do you smoke? **Y N**

If yes, what do you smoke? **Cigarettes Cigars Pipes**

How much per month do you smoke? ________________

Do you consume alcohol? **Y N**

If yes, how much do you drink? __________

What is your occupation? ______________________________

CURRENT VISION

Glasses: Do you currently wear glasses? **Y N** *if yes, answer the questions below; if no, continue to contact lenses section:*

What type of lenses are in your glasses? **Single vision Bifocal Trifocal No-line (Progressive)**

Contact Lenses: Do you currently wear contact lenses? **Y N** *if yes, answer the questions below; if no, continue to past ocular history section:*

What type of contact lenses do you wear? **Soft Rigid**

What is the manufacturer/model of your contact lenses? _____________________________________

What are the powers of your contact lenses (if you know)? _____________________________________

How old are your current contact lenses? ______ **Months / Years**

How often do you replace your contact lenses? **Daily Weekly 2 weeks Monthly 3 months 6 months Annually**

What solutions do you use to care for contact lenses? **Renu Optifree Clear Care Boston Advance Boston Simplicity Optimum Other:** ______

REVIEW OF SYSTEMS

Ocular/Eye Problems

Inflammatory disorder	**Y N**
Surgery	**Y N**
Glaucoma	**Y N**
Amblyopia (lazy eye)	**Y N**
Cataract	**Y N**
Retinal problems	**Y N**
Macular degeneration	**Y N**
Strabismus (eye turn)	**Y N**
Patching	**Y N**
Other	________

Constitutional Problems

Cancer	**Y N**
Fatigue	**Y N**
Developmental disability	**Y N**
Other	________

Ears, Nose, Mouth, Throat Problems

Laryngitis	**Y N**
Dry mouth	**Y N**
Hearing loss	**Y N**
Sinusitis	**Y N**
Other	________

Neurological Problems

Cerebral palsy	**Y N**
Multiple sclerosis	**Y N**
Tumor	**Y N**
Epilepsy	**Y N**
Other	________

Psychiatric Problems

Depression	**Y N**
Other	________

Cardiovascular Problems

Vascular disease	**Y N**
Stroke	**Y N**
Congestive heart failure	**Y N**
Heart disease	**Y N**
High blood pressure	**Y N**
Other	________

Respiratory Problems

Emphysema	**Y N**
Bronchitis	**Y N**
Smoker	**Y N**
COPD	**Y N**
Asthma	**Y N**
Other	________

Gastrointestinal Problems

Colitis	**Y N**
Chron's disease	**Y N**
Ulcer	**Y N**
Other	________

Genitourinary Problems

Prostate disease/cancer	**Y N**
STD	**Y N**
Kidney disease	**Y N**
Other	________

Musculoskelatal Problems

Ankylosis spondylitis	**Y N**
Fibromyalgia	**Y N**
Muscular dystrophy	**Y N**
Osteoarthritis	**Y N**
Other	________

Skin Problems

Rosacea	**Y N**
Psoriasis	**Y N**
Eczema	**Y N**
Other	________

Endocrine Problems

Insulin dependent diabetes	**Y N**
Hormonal dysfunction	**Y N**
Thyroid dysfunction	**Y N**
Non-insulin diabetes	**Y N**
Other	________

Blood/Lymph Problems

Large volume blood loss	**Y N**
Anemia	**Y N**
Other	________

Allergy/Immunologic Problems

Environmental allergies	**Y N**
Rheumatoid artheritis	**Y N**
Drug allergies	**Y N**
Lupus	**Y N**
Other	________

Do you sometimes experience dry eyes? **Y N**

Are your eyes sensitive to sunlight? **Y N**

Do you work at a computer ? **Y N**

Problems with reflections and/or glare? **Y N**

Prefer not to wear your glasses at times? **Y N**

Interested in newer contact lens technology? **Y N**

Want information on thinner / lighter lenses? **Y N**

Want information on LASIK vision surgery? **Y N**

Want a non-surgical option to LASIK? **Y N**

Do you have any children? **Y N**

Do you spend time outdoors? **Y N**

Please list your sporting activities / hobbies:

____

List any medications you are currently taking:

____

____

____

List any medicine allergies:

____

List any other allergies:

____