REGISTRATION FOR EYE CARE SERVICES

WELCOME TO THE PRACTICE OF DR. CARMELA LARINO, OD

*W*ALNUT *H*ILLS *O*PTOMETRY

"Because you know *WHO* will care for your eyes..."

P E R S O N A L

FULL NAME: ______ GENDER: ______ DOB: ______ AGE: ______

SOCIAL SECURITY #: XXX-XX-______ EMPLOYER: ______

MAILING ADDRESS/CITY/ZIP CODE: ______

E-MAIL ADDRESS: ______

HOME PHONE: ( ) ______ WORK PHONE: ( ) ______ CELL PHONE: ( ) ______

WHOM MAY WE THANK FOR REFERRING YOU TO US?

Church Ad _____ Insurance Plan _____ Friend/Relative _____ (Name:______________________)

Weekly Newspaper _____ Yellow Pages _____ Other ______________

OCCUPATION: ______ HOBBIES: ______

What SPECIAL visual demands does your occupation or hobby require? ______

COMPUTER USER? ______ If yes, what is the computer distance from your eyes? ______

What problems are you having while using the computer? ______

While using the computer.....How often do you take breaks? ______

.....What eyedrops do you use? ______

DATE OF LAST EYE EXAM: ______ DATE OF LAST PHYSICAL EXAM: ______

DO YOU WEAR EYEGLASSES? ______ DO YOU WEAR CONTACTS? ______ Type: ______

What problems are you having with your eyeglasses or contact lenses? ______

DO YOU USE SUNGLASSES? ______ DO YOU USE SAFETY GLASSES? ______

WHAT IS THE MAIN REASON FOR TODAY'S EYE EXAMINATION?: ______

H E A L T H

PLEASE CIRCLE ANY OF THE FOLLOWING EYE PROBLEMS YOU ARE CURRENTLY HAVING:

far away blurry with glasses/contacts	eye burning	eye discharge	eyestrain	double vision
far away blurry without glasses/contacts	eye dryness	eye pain	eye lump/bumps	other:
close up blurry with glasses/contacts	eye itching	eye redness	flashing lights	
close up blurry without glasses/contacts	eye watering	eye injury	floating spots	

INCLUDING YOURSELF, WHO IN YOUR FAMILY HAS/HAD THE FOLLOWING EYE CONDITIONS?

Cataract ______ Colorblindness ______ Eye Surgery ______ Macular Degeneration ______

Glaucoma ______ Eyeturn/Lazy Eye ______ Eye Trauma ______ Other: ______

INCLUDING YOURSELF, WHO IN YOUR FAMILY HAS/HAD THE FOLLOWING HEALTH CONDITIONS?

Arthritis ______ Head Trauma ______ Systemic Lupus ______ Birth Disorder ___

Cancer ______ Heart Disease ______ Thyroid Disease ______ (Type:________)

Diabetes ______ High Blood Pressure ______ Other: ______

Headaches ______ High Cholesterol ______ Surgeries _____(Type: ______________)

DO YOU USE CIGARETTES/ALCOHOL/DRUGS? ______

LIST YOUR ALLERGIES & YOUR REACTIONS: ______

LIST YOUR CURRENT MEDICATIONS & DATE STARTED: ______

LIST YOUR EYEDROPS & EYE VITAMINS: ______

OVER PLEASE

VISION INSURANCE NAME: **Always Vision/First Look** **Blue Cross/Blue Shield** **Eyemed**

March Vision **Medical Eye Services** **Medi-cal** **Medicare** **SafeHealth** **Superior**

Union **Vision Beneftis of America** **VSP** **Other:______________________________**

Primary Insurance Member's Name:______________________________Relationship to Patient____________________

Employer of Insurance Member:__________________________________Insurance ID Number:____________________

I understand that I am financially responsible for all charges for materials and services rendered to me or my dependent(s) and that I am subject to service and collection charges for unpaid balances. If insured, I authorize the release of any information necessary to process the payment of vision benefits which I assign to this office. Insurance payments issued to me will be immediately forwarded/re-issued to this office. I understand that prior authorizations by my insurance to this office does not guarantee payment. I will be financially responsible for all charges, whether or not paid by my insurance. In addition, I have read and/or seen this office's "Notice of Privacy Practices", as well as their "Notice to Patients" regarding any eyewear orders placed by me or my dependent(s). I understand that a copy of these notices are available at my request.

F I N A N C I A L

CONTACT LENS AGREEMENT

This office performs contact lens service examinations, in addition to eyeglass and eye health examinations. For those patients who wear, or are interested in wearing, contact lenses, a contact lens service examination will be performed. This contact lens service is an examination *separate* from an eyeglass and eye health examination. Therefore, contact lens services will have a fee *separate* from eyeglass and eye health examination fees. If insurance is used for contact lenses, there is usually an allowance which could help cover these contact lens service fees, in addition to contact lens material fees. Whether or not insurance is used for contact lenses, I understand that I will be financially responsible for all contact lens service examinations. In addition, I will be financially responsible for all contact lens service examinations, whether or not contact lens materials are ordered through this office. Once a contact lens service examination is completed and paid for, I understand that I am entitled to a written contact lens prescription and will request one as needed.

By signing below, I understand and agree to this office's financial policies.

SIGNATURE____ DATE__________________________