PATIENT HISTORY

Name_____ Age_____ Date_____
Reason for today's visit_____

Ocular History_____

No Yes

____ ____ Eye Surgery_____ type of surgery and date
____ ____ Eye Injury _____type of injury and date
____ ____ Glaucoma _____ year diagnosed

No	Yes		No	Yes	
____	____	Cataracts	____	____	Crossed or lazy eye
____	____	Eye Patch Therapy	____	____	Double Vision
____	____	Sudden Loss of vision	____	____	Dry Eyes
____	____	Burning/Itching Eyes	____	____	Retinal Detachment
____	____	Herpes Simplex of the eye	____	____	Other _____

Medical History

No	Yes		No	Yes	
____	____	Diabetes ____year diagnosed	____	____	Heavy Perspiration
____	____	High Blood Pressure ____year diagnosed	____	____	Mouth Sores
____	____	High Cholesterol	____	____	Chest Pain
____	____	Stroke <circle one>	____	____	Shortness of breath
Angina/Heart Disease/Heart Surgery ____ year			____	____	Wheezing
____	____	Multiple Sclerosis	____	____	Chronic Cough
____	____	Pacemaker	____	____	Heartburn, frequent
____	____	Asthma	____	____	Chronic Diarrhea
____	____	Emphysema/Bronchitis	____	____	Pain upon Urination
____	____	Recent Weight Loss, unintentional	____	____	Joint Aches
____	____	Sinus Problems	____	____	Low Back Pain
____	____	Migraine Headaches	____	____	Osteo Arthritis
____	____	Change in Mole or Skin Texture	____	____	Rashes
____	____	Thyroid Problems	____	____	Seasonal Allergies
____	____	Headaches, increasing in frequency	____	____	Dry Mouth
____	____	Ulcers, stomach	____	____	Rheumatoid Arthritis
____	____	Kidney Problems	____	____	Gout
____	____	Tuberculosis, TB	____	____	Psoriasis
____	____	Acne Rosacea	____	____	Crohn's/Ulcerative Colitis
____	____	Cancer, type_____			
____	____	Surgery in last 5 years, type_____			
____	____	Other Medical Condition, type_____			

For patients under age of twelve years:

No Yes

____ ____ Was the child premature? Birth Weight_____
____ ____ Ever had surgery? Type of surgery and Date _____
____ ____ Ever been hospitalized? Year diagnosed_____
____ ____ Eye Patch Therapy? When/ How Long?_____

PATIENT HISTORY *continued*

Name_____ Age_____ Date_____

Smoking History

No Yes

____ ____ Have you ever smoked?

Pack(s) per day ____ for _____ years

____ ____ Still Smoking? ____ year quit

Alcohol

No Yes

____ ____ Do you drink Alcohol?

_____ oz of hard liquor a day/week/month

_____ oz of wine or beer a day/week/month

Medications

Please list all medications taken, including birth control

_____

_____

_____

_____

_____

_____

Eye Drops (please list)

_____

_____

_____

No Yes

_____ _____ Artificial Tears

How often used_____?

Allergies

Please list any allergies: medications, dyes, food or hayfever. **None** (please circle if none)

_____

_____

_____

Contact Lenses

Do you wear contacts? Yes / No

Brand Name _____

Type of Lens: *soft /hard /RGP*

Daily / Weekly / Monthly/ Extended

Age of Current Lenses _____

Do you sleep in contacts? Yes / No

How many years worn?_____

Number of hours/days _____

Type of cleaning (heat/ solution)

Type of disinfectant _____

Family History

No	Yes		Relationship to you (mother/father etc.)
____	____	Cataracts	_____
____	____	Macular Degeneration	_____
____	____	Blindness	_____
____	____	Glaucoma	_____
____	____	Retinal Detachment	_____
____	____	Corneal Dystrophies or Transplant	_____
____	____	Crossed/Lazy Eye	_____
____	____	Childhood Eye Problems	_____
____	____	Eye Patch Therapy	_____
____	____	Diabetes	_____
____	____	High Blood Pressure	_____
____	____	Heart Disease	_____
____	____	Migraine Headaches	_____

Unknown Family History (adopted, or ?) _____

NO SHOWS/CANCELLATIONS

Please notify us at least 24 hours during business hours if you need to change or cancel your scheduled appointment or you will be charged a $50 fee. This fee is your responsibility and will not be billed to your insurance carrier or to workers compensation.

I understand that I will be billed a cancellation fee of $50 if I do not cancel within 24 hours of my scheduled appointment.

_____ _____

Patient's Signature Date

STATEMENT OF RESPONSIBILITY
IF YOU HAVE HEALTH INSURANCE OF ANY KIND,
PLEASE READ OUR POLICY

We will do everything we can to help you obtain reimbursement from your insurance carrier, however, the basic responsibility is yours.

INSURANCE

As a courtesy to you, we will send claims to your insurance company. However, we cannot accept the responsibility for negotiating claims with insurance companies or other parties. You are responsible for payment for services rendered within a reasonable time –

REGARDLESS OF THE STATUS OF YOUR CLAIM

In circumstances where a claim is pending, or when treatment is needed for an extended period of time, it is recommended that a payment plan be initiated. We will gladly assist in designing a plan to meet your needs.

REDUCTION OR REJECTION OF YOUR CLAIM

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects your claim, you should make any contact or explanation to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

I have read and understand the above statements.

_____ _____

Patient's Signature Date

PATIENT PRIVACY

To our patients:
In accordance with a new federal law on Patient Privacy, please read the following:

This notice is to advise you that our office has a privacy policy in place to protect your medical information. Our policy states that our office will keep record information confidential and will use it only for treatment, payment and health care operations. It gives examples of those uses. The office may release information to other doctors during emergencies, in cases of abuse and neglect and so on. Our policy also identifies your rights to access your records, to request restrictions on whom can see your records, to keep your communications with our office confidential and how you can request amendments to your medical records. You can review the actual policy or request copies of it at any time.

You have my permission to release my medical, information to the following.
Please check and list name and phone number.

_____ Patient Only

_____ Spouse _____

_____ Parent _____

_____ Relative _____

_____ Friend _____

_____ Employer _____

_____ _____

Patient's Signature Date

Leslie J. Weil, M.D.
1008 Laurel Street
San Carlos, CA 94070
Tel: 650.654.2133

To my patients using Vision Insurance:
In the course of my examination today, I may discover a medical problem that requires treatment not covered under the ***vision insurance plan.***

If that occurs, your ***medical insurance*** will be considered ***secondary*** to your vision insurance and additional charges will be billed to your medical insurance.

Additional co-pays or deductibles may apply in which case you may be receiving a bill from me at a later date as well as be responsible for payment of the co-payment today.

Date _____

Patient Signature: _____

Parent/Guardian Signature: _____

WHAT IS REFRACTION?

Refraction is the process of determining your glasses prescription and is performed for two reasons.

- First, it determines if glasses are required or if your current glasses prescription needs to bechanged.
- Secondly, and most importantly, it determines just how well you see. If your vision cannot becorrected with glasses, you may have some form of eye disease.

Although we feel refraction is important, most Medical insurance companies will ***not*** pay for this service. Our refraction charge is $80.00. If using Vision insurance, the refraction will be covered under that.

Medicare does *not* cover refraction or routine eye exam.

An eye examination can be done in order to be sure you have no serious eye disease without performing refraction, but ideally a refraction should be performed if you cannot see perfectly. Because we do not wish to present you with any "hidden" charges, we will only perform refraction with your permission.

Please indicate that you understand the purpose of refraction and if you wish to have this done.

____Yes, I do wish to have a refraction performed.
____No, I do not wish to have a refraction performed.

_____ _____

Patient's Signature Date

____Yes, I do wish to have a refraction performed.
____No, I do not wish to have a refraction performed.

_____ _____

Patient's Signature Date

____Yes, I do wish to have a refraction performed.
____No, I do not wish to have a refraction performed.

_____ _____

Patient's Signature Date

CONTACT LENS SERVICES

Contact lenses are a medical device that sits directly on the eye and thus requires additional testing beyond a typical eye exam and refraction.

I am a new Contact lens wearer_____

As a new wearer you will undergo a fitting, which may require more than one visit, and for which there will be a fitting charge ranging from $150.00 to $ 300.00 depending on the type of the fit.
At the completion of the fitting, the doctor will be able to determine which contact lenses will work best for you and you will receive a written prescription to be used to order your contact lenses.
This fitting includes the cost of all necessary trial lenses, training in the insertion and removal of the contacts, education about the care and hygiene of contact lenses and eye care related to contacts as well.

I am a recent past contact lens wearer_____

The fitting cost range is typically $75.00 to $150.00 depending on the type of fit. If you never became comfortable with the insertion and removal of contact lenses, the cost may be more similar to the new contact lens wearers.

I am a current contact lens wearer_____

There is a contact lens evaluation of $45.00 each year when you renew your contact lens prescription. This applies if there is no change in brand or type of usage. If there is a change in contact lenses, then a fitting fee of $75.00 to $150.00 may apply. If the change is limited to single vision (spherical lenses) the charge typically would be $75.00-$150.00.

Your contacts lens prescription by law will expire after one year. In order to renew the prescription, an annual appointment is necessary.

I have read and understand these charges and procedures.

_____ _____

Patient's Signature Date

LIFESTYLE QUESTIONAIRE

_____ _____

Patient's Signature Date

_____

Occupation:

This questionnaire is designed to assist your eye care professional in helping you select the perfect lenses, frames and/or contacts to suit your visual needs and lifestyle. Please take a few moments to answer the following questions.

1. Which of the following visual demands do you encounter on a regular basis?(Check all that apply)

_____Artificial lighting _____Computer work _____Potential eye hazards
_____Board work _____Natural lighting _____Reading
_____Close-up work _____Paperwork _____Other

2. Which of the following hobbies or activities do you participate in? (Check all that apply)

_____Auto repair _____Fishing _____Reading
_____Biking _____Golf _____Sewing/arts/crafts
_____Boating/water sports _____Home repairs _____Snow sports
_____Bookkeeping _____Hunting/shooting _____Spectator sports
_____Bowling _____Jogging/running _____Tennis
_____Competitive sports _____Landscaping/gardening _____Watching TV
_____Computer _____Musical instrument _____Welding
_____Drawing _____Painting _____Woodwork
_____Driving _____Pilot _____Other
_____Exercise _____Racquetball

3. Do your eyes seem bothered by glare from any of the following situations:

_____Car headlights _____Haze _____Traffic lights _____Computer monitor _____Night Driving _____Other:
_____Fluorescent lights _____Sunshine

4. If you wear contacts, do you have: (Check all that apply)

_____Current pair of prescription glasses
_____Sunglasses (purchased at a boutique, department / optical store)
_____Other:

LIFESTYLE QUESTIONAIRE *continued*

5. Do you have any metal or silicon allergies?

_____Yes _____No

6. What do you like about your current glasses or contacts (color, style, fit, etc.)?

---

7. What don't you like about your current glasses or contacts (weight, thickness, glare,etc.)?

Computer Vision Questionnaire

Please take a moment to complete this questionnaire.

Once completed, take it to your VSP doctor. Your doctor will then be more familiar with your work environment and better able to determine if you are at risk of developing Computer Vision Syndrome, or if you'll need special computer glasses.

General Information

1. **Indicate time spent:**
   On a computer at work: _____ **hours per day**
   On a computer at home: _____ **hours per day**
   On a handheld computer (e.g., Blackberry):
   _____ **hours per day**

2. **Desktop or laptop computer Use:** (circle applicable)

   My work computer is a: desktop laptop
   My home computer is a: desktop laptop

3. **Lighting in work area:** (please describe)

   Overhead/desk:

   _____

   Incandescent/ fluorescent:

   _____

4. **Are you experiencing any of the following symptoms while at your computer monitor?**

   Check where appropriate

   - ❍ Headaches
   - ❍ Sore or tired eyes (eye strain)
   - ❍ Blurred near vision
   - ❍ Glare (light) sensitivity
   - ❍ Blurred distant vision
   - ❍ Dry or watery eyes
   - ❍ Burning, itching, or red eyes (distant to near and back)
   - ❍ Back pain
   - ❍ Neck and shoulder pain
   - ❍ Double vision

5. **Do you wear glasses while working at the computer?**
   ❍ Yes ❍ No
   (If yes, please bring them with you to your eye exam.)

6. **Do you wear contact lenses while working at the computer?**
   ❍ Yes ❍ No
   (If yes, please wear them for your eye exam.)

7. **Do you view reference material while working at the computer?**
   ❍ Yes ❍ No
   (If yes, what percentage of time? _____)

In order for your VSP doctor to accurately assess your computer vision needs and possible appropriate eyewear, the following must also be completed.

Distances/Direction

8. **Viewing distance (eye to computer screen) is** _ _ inches.

9. **Viewing distance (eye to keyboard) is** _ _ inches.

10. **Viewing distance (eye to reference material) is** _ _ inches.

11. **The center of the computer screen is:** (circle one)

above eye level	equal to eye level	below eye level

If above or below, by how many inches? _____

12. **Reference material is:** (circle one)

above eye level	equal to eye level	below eye level

If above or below, by how many inches? _____

FACIAL REJUVENATION QUESTIONNAIRE

This Form Is Optional For Patients To Complete

Skin rejuvenation and protection issues of interest to you

(please check all that apply)

[ ] Wrinkles [ ] Sunscreen

[ ] Prevent/Correct Collagen [ ] Frown Lines

[ ] Uneven Skin Tone [ ] Skin Elasticity

[ ] Environmental Damage [ ] Puffy Eyes

[ ] Dark Circles Under Eyes [ ] Dryness

[ ] Redness

Please answer the following questions on a scale from 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look _____ my age

Younger than true age older than

1 2 3 4 5

When looking in the mirror, I am _____about the appearance of my skin.

Not Concerned Somewhat Concerned Very Concerned

1 2 3 4 5

How did you hear about us? _____

Would you like to have longer, thicker eyelashes? **Y / N** ?

Refer a Friend

If they book an appointment you receive **$25.00 off** your next treatment!!!

MEDICAL RECORD QUESTIONNAIRE

If you have your glasses or contacts in the car, please bring them in.

1. Have you seen any of your **other** doctors since you were last here to see Dr. Weil? Yes_____or No _____

1. Which pharmacy do you use for your prescriptions?

Name: _____City: _____Street Name: _____

2. Do you wish to receive e-mail statements?

Yes_____or No _____ E-mail address: _____

As a requirement for electronic medical records and Medicare we are required to ask you to complete these questions.

Name: _____

Please indicate ethnicity and race:

RACE

_____ American Indian / Alaskan Native

_____ Asian

_____ Black / African American

_____ Caucasian

_____ Other

_____ Pacific Islander

_____ Declined

ETHNICITY

_____ Hispanic / Latin

_____ Non Hispanic / Latino

_____ Declined