**Welcome to Beverly Hills Optometry**

Today’s Date: Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M/F

Patient Name: Mr. Mrs. Ms. Miss. Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (if patient is a minor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_

Phone: Home: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hobbies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You are interested in: \_\_\_\_Comprehensive Eye Exam \_\_\_\_Contact Lens Evaluation \_\_\_\_ Other Eye Condition

\_\_\_\_Advanced Eye Exam \_\_\_\_ Order Contact Lenses \_\_\_\_ Laser Vision Correction

**Insurance Information**

(Please present any vision/medical cards at check in)

**Vision:** (Please Circle) Eyemed Superior VSP Avesis Spectera Cigna Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (of primary insured): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of SS#\_\_\_\_\_\_\_\_\_

**Medical PPO:** (Please Circle) BlueCross BlueShield Aetna Medicare Cigna United Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (of primary insured): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of SS#\_\_\_\_\_\_\_\_\_

**Medical Information**

Do you wear: Glasses -> Distance/Computer/Reading/Bifocal/Progressive

Contacts -> Daily wear/Extended wear/ Astigmatism/Multifocal/Monovision/soft/rigid gas perm

Satisfaction with current glasses/contacts: Low 1 2 3 4 5 6 7 8 9 10 High

Do you use any eye care medications (prescriptions and/or over-the-counter): Y/N

if yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any injuries or surgeries to your eyes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications, supplements, and/or over-the-counter medications you are currently using:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to medications: Y/N if yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any seasonal/food allergies: Y/N if yes, please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you: \_\_\_\_\_smoke? \_\_\_\_\_drink alcohol? \_\_\_\_\_abuse substances? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following that apply and circle for you (S) or family member (F):

\_\_Blur at distance \_\_Eye Fatigue \_\_Problems with glare \_\_High Blood Pressure (S/F) \_\_Glaucoma (S/F)

\_\_Blur at near \_\_Eye Strain \_\_Sensitive to light \_\_Diabetes (S/F) \_\_Cataracts (S/F)

\_\_Blur after reading \_\_Eyes itch \_\_Seeing spots \_\_Thyroid (S/F) \_\_Color blindness (S/F)

\_\_Double vision \_\_Eyes water \_\_Asthma (S/F) \_\_Lazy Eyes (S/F) \_\_HIV+/AIDS (S/F)

\_\_Headaches \_\_Light flashes \_\_Dry Eyes \_\_Cancer\_\_\_\_\_\_(S/F) \_\_Macular Degeneration (S/F) \_\_Pregnant\_\_mo \_\_Other

Family History of Eye Disease: Y/N If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History of Diabetes: Y/N If yes, explain\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We are glad that you have chosen Beverly Hills Optometry as your eye care provider. Please read the important notifications below, so that you may become familiar with our practice policies.**

**Insurance Assignment and Release**

I certify that I have insurance coverage with the company(ies) I provided and assign directly to Dr. Silani and Beverly Hills Optometry, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize the use of signature on all insurance submissions. This consent will end when my current treatment plan is completed or one year from the date signed below.

**Vision Plan (Routine) Insurance**

I acknowledge that Vision Plan (Routine) Insurance covers routine eye examinations, refractions, and may cover materials (contact lenses, glasses, ect) as specified by my plan benefits. I understand that Medical Examinations and Treatments are NOT covered under my Vision Insurance. I understand that Services related to medical conditions will be billed to my Medical Insurance or, if no applicable medical coverage exists, these services are my responsibility at the time of service.

**Medicare/Supplement Authorization**

I request that payment of authorized Medicare benefits, if applicable, supplement benefits, be made to Beverly Hills Optometry for any services furnished to me. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare Services, my supplement insurer, and their agents any information needed to determine these benefits or benefits

**Refraction**

Refraction (testing for best corrected Visual Acuity) is not covered by medical insurance. In the absence of qualifying vision Insurance coverage, Refraction fees are the responsibility of the patient. Best Correct Visual Acuity Refraction**-$50**

**Dilation**

Please note that your eyes may be dilated during your examination. Dilation of your pupils may blur your vision and make you sensitive to light for several hours after your examination. It is important to refrain from driving and performing precision work with tools when your vision is blurred from dilation. It is not possible to predict how long the effect of dilation will last or how much your vision will be affected, although most patients recover within 4 hours. We recommend that you wear sunglasses when your eyes are dilated.

**Pharmacy Prescriptions**

You may be given a prescription for medications in conjunction with your care. It is important that you check with your pharmacist and/or primary care physician regarding potential interactions with other medications you are currently taking.

**HIPAA Privacy Practices**

Beverly Hills Optometry follows HIPAA guidelines in regard to your PHI (Protected Health Information). I understand that I have certain rights to privacy regarding my protected health information. Copies of our HIPAA Policy are available at the Front Desk.

**Co-pays, Deductibles and Non Covered Services**

I acknowledge that I am financially responsible for co-pays, deductibles and non covered services; and that those amounts will be collected at the time of service.

**Billing and Collections**

I acknowledge that Beverly Hills Optometry is providing services in good faith and they will be appropriately compensated in a timely manner. It is the patient’s and/or guarantor’s responsibility to provide Beverly Hills Optometry with updates billing and insurance information on each visit. Beverly Hills Optometry has a “All Sales Final/No Returns” policy. Orders that have been cancelled will be available for exchange or in office credit only.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Upgrade to a more advanced Comprehensive Exam**

Retinal Digital Photography, Optical Coherence Tomography and Dry Eye Imaging may or may not be covered by insurance. In the absence of qualifying vision or medical insurance coverage, fees are the responsibility of the patient.

**All tests help provide the highest quality of care. Please initial which elective imaging tests you want to receive.**

**Retinal Digital Photography-$50 \_\_\_\_\_\_\_\_\_\_**

The Retinal Photograph is useful for early detection, monitoring, and/or treatment of eye and body conditions like **macular degeneration, diabetes, glaucoma, high blood pressure, high cholesterol, some cancers** and many more. It serves as a tool for preventative medicine and digitally documents the health of the retina for annual comparisons. **Strongly recommended for first time patients OR patients with a personal/family history of any of the above mentioned.**

**Optical Coherence Tomography (OCT)-$50\_\_\_\_\_\_\_**

Optical coherence tomography (OCT) is a non-invasive imaging test, similar to an MRI for the eye, to scan for eye diseases. OCT uses light waves to take cross-section pictures of your cornea and retina.This allows Dr. Silani to map and measure their thickness. These measurements help with diagnosis of diseases of the retina. These retinal diseases include [age-related macular degeneration (AMD)](https://www.aao.org/eye-health/diseases/amd-macular-degeneration), glaucoma and [diabetic eye disease](https://www.aao.org/eye-health/diseases/what-is-diabetic-retinopathy). Dr. Silani can see and document the slightest change from year to year. **This is necessary for patients considering Lasik.**

**Dry Eye/Blepharitis/Stye/Allergy Imaging-$50\_\_\_\_\_\_\_\_**

The OCULUS Keratograph® 5M is an advanced corneal topographer with a built-in keratometer and infrared color, camera optimized for external imaging of the eye and eyelid. Unique features include examining the meibomian glands, measuring the tear quality, evaluating the tear meniscus height and tracking the vessels of the conjunctiva. **Recommended for patients with eye irritations, watery eyes, blurry vision, dryness, redness, styes, blepharitis, contact lens patients, etc.**

**Advanced Comprehensive Exam Package (all three)- $125\_\_\_\_\_\_\_\_\_**

**\*None of these tests require dilation\***

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_