

# PATIENT REGISTRATION FORM

## PATIENT INFORMATION

Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Number \_\_\_\_\_

Female / Male      Single / Married / Other

Whom would we call in an Emergency? \_\_\_\_\_

Phone Number \_\_\_\_\_

Referral Source \_\_\_\_\_

Patients Employer \_\_\_\_\_

Occupation \_\_\_\_\_ How long? \_\_\_\_\_

Email \_\_\_\_\_

Social Security # \_\_\_\_\_

Patients Primary Doctor \_\_\_\_\_

## INSURANCE INFORMATION

Name of ***Medical*** Insurance \_\_\_\_\_

Primary Cardholders Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Relationship to you? \_\_\_\_\_

Secondary ***Medical*** Insurance \_\_\_\_\_

***Vision*** Insurance \_\_\_\_\_

Primary Cardholders Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

**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 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)

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## 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 ?) \_\_\_\_\_



WEIL EYE CARE MEDICAL CENTER

**Leslie J. Weil, M.D.**

1008 Laurel Street

San Carlos, CA 94070

Tel: 650.654.2133 Fax: 650.654.2170

## **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



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### **To my patients using Vision Insurance:**

In the course of my examination today, Dr. Weil may discover a medical problem that requires treatment not covered under the Vision Insurance Plan. If that occurs, our office will be submitting additional charges to your medical insurance. Additional co-pays or deductibles may apply in which case you may be receiving a bill from our office at a later date as well as be responsible for payment of the co-payment today.

Patient Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

## WHAT IS REFRACTION?

Refraction is the process of determining your glasses prescription.

Refraction is performed for two reasons. First, it determines simply if glasses are required or if your current glasses prescription needs to be changed. Secondly, and most importantly, it determines just how well you see. If your vision cannot be corrected 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. Medicare does not cover refraction or routine eye exams.

Our charge for refraction is \$80.00. If you have vision insurance, such as Vision Service Plan (VSP), Medical Eye Service (MES), and Eye Med, most of this charge may be covered.

Of course, it is possible for us to perform an eye examination in order to be sure you have no serious eye disease without performing refraction. Ideally, an eye exam should include refraction 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 sign this statement to indicate that you have read and understood the purpose of refraction. Please indicate if you wish to have refraction.

\_\_\_\_\_ **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 QUESTIONNAIRE

\_\_\_\_\_  
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)

<input type="checkbox"/> Artificial lighting	<input type="checkbox"/> Computer work	<input type="checkbox"/> Potential eye hazards
<input type="checkbox"/> Board work	<input type="checkbox"/> Natural lighting	<input type="checkbox"/> Reading
<input type="checkbox"/> Close-up work	<input type="checkbox"/> Paperwork	<input type="checkbox"/> Other

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

<input type="checkbox"/> Auto repair	<input type="checkbox"/> Fishing	<input type="checkbox"/> Reading
<input type="checkbox"/> Biking	<input type="checkbox"/> Golf	<input type="checkbox"/> Sewing/arts/crafts
<input type="checkbox"/> Boating/water sports	<input type="checkbox"/> Home repairs	<input type="checkbox"/> Snow sports
<input type="checkbox"/> Bookkeeping	<input type="checkbox"/> Hunting/shooting	<input type="checkbox"/> Spectator sports
<input type="checkbox"/> Bowling	<input type="checkbox"/> Jogging/running	<input type="checkbox"/> Tennis
<input type="checkbox"/> Competitive sports	<input type="checkbox"/> Landscaping/gardening	<input type="checkbox"/> Watching TV
<input type="checkbox"/> Computer	<input type="checkbox"/> Musical instrument	<input type="checkbox"/> Welding
<input type="checkbox"/> Drawing	<input type="checkbox"/> Painting	<input type="checkbox"/> Woodwork
<input type="checkbox"/> Driving	<input type="checkbox"/> Pilot	<input type="checkbox"/> Other
<input type="checkbox"/> Exercise	<input type="checkbox"/> Racquetball	

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

<input type="checkbox"/> Car headlights	<input type="checkbox"/> Haze	<input type="checkbox"/> Traffic lights
<input type="checkbox"/> Computer monitor	<input type="checkbox"/> Night Driving	<input type="checkbox"/> Other:
<input type="checkbox"/> Fluorescent lights	<input type="checkbox"/> 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 QUESTIONNAIRE *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.)?**

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

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# 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:

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### 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                      equal to                      below  
eye level                      eye level                      eye level

If above or below, by how many inches? \_\_\_\_\_

12. Reference material is: (circle one)

above                      equal to                      below  
eye level                      eye level                      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)

- |   |  |
|---|--|
| <input type="checkbox"/> Wrinkles                 | <input type="checkbox"/> Sunscreen       |
| <input type="checkbox"/> Prevent/Correct Collagen | <input type="checkbox"/> Frown Lines     |
| <input type="checkbox"/> Uneven Skin Tone         | <input type="checkbox"/> Skin Elasticity |
| <input type="checkbox"/> Environmental Damage     | <input type="checkbox"/> Puffy Eyes      |
| <input type="checkbox"/> Dark Circles Under Eyes  | <input type="checkbox"/> Dryness         |
| <input type="checkbox"/> 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
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

When looking in the mirror, I am \_\_\_\_\_ about the appearance of my skin.

Not Concerned		Somewhat Concerned		Very Concerned
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

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!!!