

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)

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



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 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. 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 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)

____ 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 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.)?

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 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		
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!!!