OC Eye Designs Optometry

Exclusive Eyewear · Exquisite Eyecare

Welcome to our practice. We are excited that you selected us as your eye care provider and appreciate the opportunity to help you with all of your eye care and eyewear needs. With over 40 years combined experience, our doctors specialize in Primary Care, Pediatrics and Low Vision. As a private practice we are committed to providing a lifetime of care for you and your family.

During your visit, our doctors will perform a comprehensive eye examination. Regular eye exams are important in helping you maintain good vision and can detect a number of serious health conditions such as glaucoma and diabetes. Plus, eye exams for children and young adults can spot problems that can impact learning and development.

We are sure that you will want to get your eye examination started soon after you arrive. So, to help process your paperwork, we ask that you complete the enclosed forms and bring them to your visit. These forms will help us get acquainted with you so we can better assess your eye care and visual needs. The information you provide can also help us make recommendations about different eyewear options to fit your specific needs and lifestyle.

Thank you for choosing OC Eye Designs. We are looking forward to meeting you. If you have any questions prior to your visit, or need to make a change to your appointment, please contact us at 714-545-9162.

Sincerely,

The OC Eye Designs Team

1545 Adams Suite 100, Costa Mesa, California 92626 Phone: 714-545-9162 Fax: 714-241-1345
www.oceyedesigns.com

OC Eye Designs Optometry

PATIENT INFORMATION

PERSONAL INFORMATION –PLEASE FILL IN ALL FIELDS

Name: _____ **Sex:** M / F
LAST FIRST MIDDLE INT

Date of Birth: _____/_____/_____ **Social Security #:** _____ - _____ - _____ **Drivers License #:** _____

Mailing Address: _____
NUMBER & STREET CITY / ST ZIPCODE

Phone: Cell (_____) _____ - _____ Home (_____) _____ - _____ Other/Work (_____) _____ - _____

Email Address: _____ **Occupation:** _____ **Employer**: _____

Whom may we thank for referring you to our office?_____

VISION Insurance Information:

VSP _____ Medical Eye Services(MESC) _____ EYEMED _____ SAFEGUARD _____ OTHER_____

Primary Member's Name: _____ Primary Members Date of Birth: _____

Primary Member's Social Security Number: _____ - _____ - _____ Relationship to Patient**:** _____

****** PLEASE PRESENT MEDICAL INSURANCE CARDS TO FRONT DESK ******

AGREEMENT(S)

I authorize OC Eye Designs and staff to release any medical information necessary to my insurance company to process this claim. This authorization shall apply to all claims submitted on my behalf or for my dependants.

I also authorize payment of medical and/or vision insurance benefits to OC Eye Designs. I understand that I am financially responsible to OC Eye Designs for the charges not covered by my insurance as well as any deductible and/or coinsurance.

I understand and agree that payment is required at the time services are rendered.

Signed: _____ **Date:** _____

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OC Eye Designs Optometry
1545 Adams Ave Ste 100
Costa Mesa, CA 92626
Phone:714-545-9162
Fax: 714-241-1345
patientcare@oceyedesigns.com

Patient Health History

Please review, make necessary changes and supply any missing information. **Date:**

Patient Name				**Date of Birth**	
Primary Care Physician		**Reason for Last Visit**		**Approximately when was your last visit**	
Last Eye Doctor				**Approximately when was your last eye exam**	

Review Of Systems	
Please list any current illnesses, symptoms or problems	
Constitution	
Cardiovascular	
Ears, Nose, Mouth, Throat	
Respiratory / Lungs	
Stomach / Intestines	
Urinary / Reproductive	
Bones / Joints / Muscles	
Skin / Hair / Nails	
Neurological	
Psychiatric	
Endocrine / Hormonal	
Blood / Circulation	
Allergic / Immunologic	
Other	

Diabetic Information
☐ **Self Monitoring Blood Sugar test** ☐ **Hemoglobin A1c test**
Date of Last Recorded Test:
Value:
Location / Timing: ☐ Before ☐ Breakfast ☐ Lunch ☐ Dinner ☐ **After** ☐ ☐ **Breakfast** ☐ **Lunch** ☐ **Dinner**

Surgical Information

Date	**Eye**	**Procedure**	**Surgeon**	**Complications**

Past Medical History	
Please list any past medical conditions	
Condition details	

Past / Present Ocular History		
Please list any past or present ocular illnesses, symptoms or problems		
Glaucoma		
Cataracts		
Age-Related Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Strabismus		
Amblyopia		
Diabetes		
Dry Eye		
Refractive		
Other		

Do you work on a computer ?		**Hours per day**	

Social History	
What type of recreational drugs do you use?	
What type of alcohol do you drink, how much and how often?	
Are you a smoker, former smoker or never smoked? Do you smoke everyday or some days?	
What type of tobacco do you use, how much, how often and for how long?	
Occupation	
Work status / duties	
Hobbies	

Family History

Please list any family members with these conditions

MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents)

Glaucoma	
Cataracts	
ARMD	
Eye Injury	
Retinal Disease	
Other Disease	
Blindness	
Strabismus	
Amblyopia	
Diabetes	
Cancer	
Heart Disease	
Hypertension	
High	

Family History

Please list any family members with these conditions

MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents)

Cholesterol	
Kidney Disease	
Other	
Other	

Allergies

Allergy	**Onset Date**	**Reaction**	**Severity**

Medications

Please cross out any medications that you are no longer taking
Please list all prescriptions, over the counter and herbal medications

Date	**Name**	**Strength**	**Directions**

Contact Lens History

Type of Contact lenses you currently use (gas permeable, soft daily, extended)				**How often do you replace your contacts?** (daily, weekly, monthly)	
Average number of hours that you wear your contacts		**Number of hours worn today**		**Wearing Type** (daily, extended)	Extended wear

Medical Alerts

Please list all medical alerts (i.e., Do Not Dilate, epilepsy, DNR / DNI)

Dry Eye Questionnaire

Name:_____ Date:___/___/___

How **FREQUENTLY** do you experience the following dry eye symptoms?

Symptoms	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

How **SEVERE** are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – Irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Does your face flush after drinking alcohol or exercising? Yes No (Circle)

Do you have trouble seeing at night while driving? Yes No (Circle)

For office use only
Total score (Frequency + Severity) = _____/28

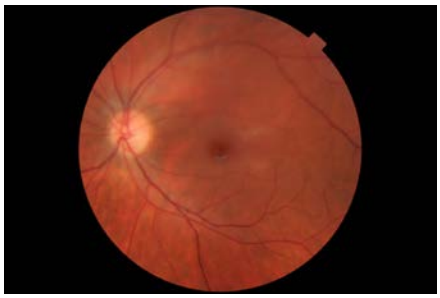
OC Eye Designs Optometry

In an effort to provide a more thorough and state of the art eye exam, our practice has incorporated the iWellnessExam™ SD- OCT retinal scan and digital retinal imaging as part of your eye exam today.

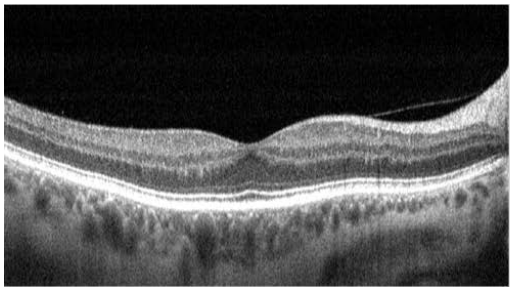
Our doctors recommend that **all our patients** have this test. It is especially important for those with a history of and/or a family history of:

- ✓ Diabetes
- ✓ High blood pressure
- ✓ Glaucoma
- ✓ Macular Degeneration
- ✓ Retinal diseases
- ✓ Flashing lights
- ✓ Decreased or distorted vision
- ✓ A strong glasses prescription

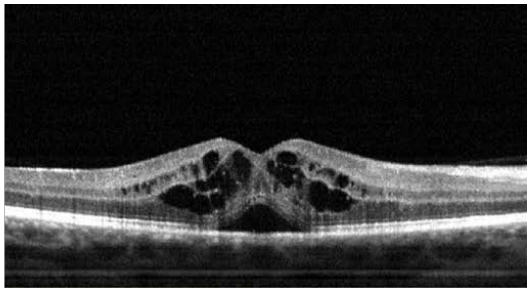
Even if you see well, many retinal conditions **do not produce symptoms** such as pain or blurred vision. These tests help in early detection of retinal problems to avoid vision loss and preserve superior eye health. Our technician will perform these two tests before you go into the exam room and Dr. Wald, Dr. Ansari, or Dr. Ngo will review these with you during your examination today. These two tests will become a part of your permanent patient record.



Normal retinal photograph



Normal retinal cross section iWellness OCT



Diseased retina visible to iWellness OCT exam often invisible to photos and ophthalmoscopy

The $49 charge is typically not covered by your medical or vision insurance. This cost will be added into the price of your visit today. Upon request, this office will advise you of your coverage, and you may be required to submit a receipt for reimbursement from your insurance provider.

_____ **Yes, I want to have retinal photos taken as part of my eye exam.**

_____ No, I decline the recommendation to have retinal photos taken.

Signature: _____ Date: _____

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Dilation is an important part of a complete eye exam. Dilation will make your pupil (the black part in the center of your eye) large so that the doctor can get a better look at the back of the eye to check for any problems that can occur due to the following:

- Systemic Diseases, such as Diabetes, High Blood Pressure, Cancer, etc. that can affect the eyes without obvious symptoms to the patient.
- Physical Changes in your eyes, such as cataracts, glaucoma, retinal detachment, etc. that can affect your vision

The dilation will make reading things up close difficult, and make lights seem brighter than usual. This will last for 3-4 hours, although it can last longer in some people. Most people will be able to drive once their eyes are dilated, as long as they have sunglasses (which we can provide if you didn't bring any). However, if you feel uncomfortable driving, or have never driven with your eyes dilated, it may be best to have a driver. Please note there is no additional charge for having your eyes dilated.
It is highly recommended to have your eyes dilated if:

- You are new to our office
- You are diabetic
- You are over age 45
- You have a glasses or contact lens prescription over -4.00
- Have been previously diagnosed with a condition in the back of the eye that needs yearly monitoring

If you do not fit in the above categories, it is still recommended to have your eyes dilated at least every two years.
Please check one of the following:

☐I would like my eyes dilated today if the doctor believes it is necessary
☐I would like to schedule a time to come back for the dilation (no additional charge)
☐I do not want my eyes dilated (see below)

In refusing to have my eyes dilated, I understand that I am assuming all risks, including blindness, associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

Patient Signature: _____ Date:_____
Print Name:_____

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Receipt of Notice of Privacy Policies & Consent Form

OC Eye Designs Optometry
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Costa Mesa, CA 92626
(714) 545-9162

Patient Name: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these use and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices,* the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices.* Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices.*

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices,* we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from OC Eye Designs Optometry.

_____ _____

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient Print Name

Source of Authority: _____

PEN Publications 800-444-9230