

Welcome to Our Office

So that we can help you best, please fill out both pages legibly and completely. Thank You!

Full Name _____	Today's date _____
Name you go by (if different) _____	Approximate date of last eye exam _____
Home address _____	Date of birth _____ Sex: M F
City _____ State _____ Zip _____	Social security number _____
Home phone ____ (____) _____	Employer (or School) _____
Work phone ____ (____) _____	Occupation (or Grade) _____
Cell phone ____ (____) _____	Emergency contact name _____
E-mail address _____	Emergency contact phone (____) _____

Name of Family Members at Home	Relationship	Age	Current Patient of Ours?
			Y N
			Y N
			Y N
			Y N

Medical Insurance _____	How will you settle your account today?
Do you participate in a flexible spending account? Y N	<input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card

Are you a member of an eye care plan? Y N (if yes, circle your plan below and sign to authorize benefits)

Vision Service Plan (VSP) Medical Eye Services (MES) Eye Med Superior Vision Other _____

I authorize the payment of any eye care benefits indicated above to my Doctor of Optometry. I understand that I may have co-payments and overages (costs not paid for by the eye care plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: _____ Date _____

Personal Medical History	How did you <i>first</i> hear about our office?																														
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Allergies</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> <td style="width: 15%;">Eye Disease</td> <td style="width: 10%;">Y</td> <td style="width: 10%;">N</td> </tr> <tr> <td>Asthma</td> <td>Y</td> <td>N</td> <td>Eye Surgery</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Arthritis</td> <td>Y</td> <td>N</td> <td>Eye Injury</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Cancer</td> <td>Y</td> <td>N</td> <td>Heart Disease</td> <td>Y</td> <td>N</td> </tr> <tr> <td>Diabetes</td> <td>Y</td> <td>N</td> <td>High Blood Pressure</td> <td>Y</td> <td>N</td> </tr> </table>	Allergies	Y	N	Eye Disease	Y	N	Asthma	Y	N	Eye Surgery	Y	N	Arthritis	Y	N	Eye Injury	Y	N	Cancer	Y	N	Heart Disease	Y	N	Diabetes	Y	N	High Blood Pressure	Y	N	<input type="checkbox"/> Family, friend, or co-worker. Who? _____ <input type="checkbox"/> Doctor referral. Who? _____ <input type="checkbox"/> Eye care plan directory. <input type="checkbox"/> Yellow pages. Which directory? _____ <input type="checkbox"/> Internet. Which website? _____ <input type="checkbox"/> Other. Please specify. _____ _____
Allergies	Y	N	Eye Disease	Y	N																										
Asthma	Y	N	Eye Surgery	Y	N																										
Arthritis	Y	N	Eye Injury	Y	N																										
Cancer	Y	N	Heart Disease	Y	N																										
Diabetes	Y	N	High Blood Pressure	Y	N																										

<p>Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)</p> <p>Are you allergic to any medicines? Y N (If yes, please list)</p>	<p><i>Please complete the second page . . .</i></p> <p>Copyright © 2005 Li & Liao Optometry, P.C. All rights reserved.</p>
---	---

Welcome to Our Office, Page 2

Family Medical History			
Blindness or Visual Disability	Y	N	Unsure
Cataracts	Y	N	Unsure
Diabetes	Y	N	Unsure
Glaucoma	Y	N	Unsure
High Blood Pressure	Y	N	Unsure
Macular Degeneration	Y	N	Unsure
Other disease (please specify) _____			

Eye Care for Your Lifestyle			
Do you desire glasses that are thinner, lighter, and more comfortable?	Y	N	
Do you spend much time outdoors?	Y	N	
Do you spend much time working on a computer?	Y	N	
Are your eyes very sensitive to bright lights?	Y	N	
Are you bothered by glare and reflections, especially at night?	Y	N	
Are you interested in wearing the most advanced contact lenses?	Y	N	
Would you like to change your eye color?	Y	N	
Are there times you would rather not wear glasses or contact lenses?	Y	N	
Do you suffer from dry eyes?	Y	N	
If you wear prescription glasses, do you have only one pair?	Y	N	N/A
If you wear bifocal glasses, does the line bother you?	Y	N	N/A
If you wear bifocal or progressive glasses, do you ever wish you could wear contacts?	Y	N	N/A
So that we can get to know you better . . . What hobbies, sports, or other activities do you enjoy?			

I acknowledge that I have received a copy of Dr. Li & Dr. Liao's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, www.BakersfieldEyeDoc.com.

Patient name _____ Today's Date _____

Signature of patient (or parent/guardian for minors) _____

Thank you!

Digital Retinal Imaging

Dear Patient,

A computerized instrument now allows us to provide you with a more thorough medical analysis of your eye. The digital retinal imaging camera takes digital pictures of the retina (nerve layer inside the back of your eye). This procedure assists the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, hypertensive retinopathy, and other sight threatening conditions. The pictures are stored in our data base and will be used to compare with future images to observe for any future changes in the health of the inside of your eyes.

The doctor strongly recommends that patients of all ages have this procedure performed annually as part of their *routine* eye examination. It is especially important for people who have:

1. Headaches
2. Diabetes
3. High Blood Pressure
4. High Cholesterol
5. 40 years of age and older
6. Family History of Glaucoma, Macular degeneration, and/or Blindness
7. Family History of Diabetes and/or High Blood Pressure
8. New patients

Medical and Vision insurances **do not** pay for *routine* photos. The charge for *routine* photos is **\$35**. If there is a medical diagnosis found, your medical insurance may pay for this procedure. This usually requires a written interpretation/report by the doctor and additional fees will be submitted to your insurance company. The doctor will not know prior to your exam if there is a medical diagnosis that would allow for insurance submission.

Please check the appropriate line and sign at the bottom.

Yes, I would like the imaging procedure performed.

No, I decline to have the imaging procedure performed.

Signature of Patient (or Parent if under 18 years old)

Date

Patient Name (Please Print)