SEASIDE EYECARE

Optometry

Dr. Jean Lim, OD

Treatment of Eye Diseases – Lasik and Laser Consultant – Specialty Contact Lens

PERSONAL INFORMATION

Date:_______/_______/_______
Name: (Last)________________________________(First)______________________________(Middle)________________
Address:____City_________________________State_____ Zip______________
Home Phone: (___)_________________ Business Phone: (___)_________________ Cell: (___)_________________
Sex: M / F Age: ________ Date of Birth_______/_______/_______ Social Security#:________/_______/________
Profession:_____________________________________ Employed by:____
Email:________________________@_____________. Who may we thank for referring you? ___________________
Vision Plan Y / N Name of Plan: ___________________ Health Plan: Y / N Name of Plan: ___________________
Last Eye Examination:(Date)______/______/______ Dr's Name: ____
Reason for today's visit:____
Spouse/Emergency Contact: (Name)___________________________________ Phone: (___)____________________

Are you experiencing any of the following? (Check all that apply)

- □ **Blur at distance**
- □ **Blur when reading**
- □ **Visual discomfort**
- □ **Dry eyes**
- □ **Itching/Burning**
- □ **Discharge/Tearing**
- □ **Floaters/Spots**
- □ **Flashes of light**
- □ **Foreign body sensation**
- □ **Headaches**
- □ **Light sensitivity**
- □ **Ocular pain**
- □ **Redness**
- □ **Other: _________ ________________**
- □ **None**

PERSONAL EYE INFORMATION

Have you had any of the following:
Eye Operation/Injury? Y / N Type_____________________________________Date______/______/______
Glaucoma? Y / N Cataracts? Y / N Other eye problems? _______________________________________
Do you wear glasses? Y / N Contacts? Y / N Type____
Additional Information:____

MEDICAL INFORMATION

What is your general health?____ Are you pregnant? Y / N
Do you have: Diabetes? Y / N Type_______________________________ Diagnosed (Date) ______/______/______
High Blood Pressure? Y / N High Cholesterol? Y / N
Do you have problems with any of these systems? (Check all that apply)

- □ **Cardiovascular**
- □ **Blood disorders**
- □ **Breathing problems**
- □ **Ear/Nose/Throat**
- □ **Allergies**
- □ **Autoimmune ds**
- □ **Thyroid condition**
- □ **Kidney/Liver**
- □ **Neurological ds**
- □ **Mood ds**
- □ **Skin condition**
- □ **other: _____________ ___________________**
- □ **None**

Please Explain: ____

Current Medication(s) ____

Are you allergic to any medications Y / N Please Explain: ____

Have you had any operations? Y / N What Kind? ____
Do you use cigarettes/tobacco? Y / N Alcohol? Y / N Other Substances? Y / N
Name of family doctor____Date of last exam______/______/______

FAMILY HISTORY

Does anyone in your family have:
Diabetes? Y / N Relation______________________High blood pressure? Y / N Relation_____________________
Glaucoma? Y / N Relation_____________________Macular Degeneration? Y / N Relation___________________
Retinal Detachment? Y / N Relation_____________Other eye conditions Y / N What kind? Relation____________

AUTHORIZATION TO PAY MEDICAL AND OPTICAL BENEFITS DIRECTLY TO ATTENDING PHYSICIAN

For those patients with specific vision insurance for which we are providers (VSP, MES, etc.): I hereby authorized my insurance carrier (both primary and secondary carriers) to make payments directly to **SEASIDE EYECARE OPTOMETRY (DR. JEAN LIM OPTOMETRY, INC.).** I understand that I am financially responsible for any and all charges not covered by my insurance benefits.

REFRACTIONS

Refraction is the measurement of the eyes for glasses. Most insurance plans, including **MEDICARE**, do not consider this to be a medical procedure, and therefore do not provide medical insurance coverage for this. If you choose to have refraction, you will be required to pay a fee of **$20** for **MEDICARE** patients **at the time services are rendered**, and/or full fees according to your insurance plan.

CONTACT LENS EXAMINATION

For your health and safety, we require annual contact lens evaluations. A separate fee **(starting at $95.00)** is charged beyond the routine eye exam. We determine the fit, the health and condition of the eyes with contacts. We also evaluate changes in prescription and lens design during this process.

WARNING ABOUT DILATION

As a part of the eye examination, it will be necessary to dilate the pupils of the eye. This may hinder your ability to safely drive and your work may be impaired for up to six hours by blurred vision, glare, or light sensitivity. Dr. Lim will be discussing this with you.

WARNING ABOUT PREGNANCY

If you are pregnant or think you may be pregnant, you must notify the staff and doctor prior to receiving any eye drops. This is your responsibility.

ADDITIONAL TESTING

During the visual examination, certain conditions (such as **GLAUCOMA, KERATOCONUS, & CORNEAL DISTORTION**) may necessitate the use of special equipment to confirm the diagnosis. There will be additional charges for this special testing:

TOPOGRAPHY to diagnose Keratoconus, a corneal disease	$50.00
VISUAL FIELD to diagnose loss of vision due to Glaucoma	$150.00

NOTICE OF PRIVACY POLICY & CONSENT

As described in our Notice of Privacy Practices, the use and disclosures of your health information for treatment purposes not only includes care and services 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.

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

DELINQUENT ACCOUNTS

We will try our best to collect without having to seek legal advice. In case of legal disputes, the patient will have to absorb all legal fees, including court cost and attorney's fees. A $25.00 fee will be collected from the patient for any returned, unpaid check.

___________________________	___________________________	_________________
Print Name of Patient	Signature of Patient	Date

For Minors:

___________________________	___________________________	_________________
Print Name of Guardian/Relationship	Signature of Guardian	Date

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED