Oakland Vision Center Optometry

1960 Broadway, Oakland CA 94612 · 510-893-5566 · page 1 of 4

Welcome! Thank you for choosing our practice for your eye care. We strive to provide personal and caring medial service in an atmosphere of respect and privacy. If you have any questions or concerns, please do not hesitate to ask for help at any time. To help serve you better, please answer the following questions.

PATIENT REGISTRATION RECORD

Patient Legal Name (Last, First, Middle)	Preferred First Name	Date of Birth	Legal Gender O Male O Female	O Single O Married O Domestic Partner

Mailing Address	City	Zip Code

Home Phone	Work Phone	Cell Phone

Social Security # of patient:	Driver's License #	Email for reminders

Occupation? Student?	Where do you work? / What is the name of your school?

Name of primary insurance carrier (spouse, domestic partner or parent)	Primary's Social Security #	Primary's Date of Birth

Name of person to notify in an emergency	Relationship	Phone

Who referred you to our office?	O Friend / Co-worker O My doctor O Insurance provider O Other:	What internet site helped make your decision?	O Yelp.com O Google / Google+ O Oakland Vision Center website O Other:

INSURANCE INFORMATION

Name of Major Medical Insurance (Blue Cross / Kaiser)	Name of Insured
Medical card ID#	Group # (if any)
Vision Plan Name for Glasses/Contacts (VSP, Eyemed)	

PLEASE READ & SIGN. Routine eye exams, refraction (glasses prescription), contact fitting or contact lenses, may not be covered by insurance; In these cases the patient is responsible for payment. A referral is not a guarantee of payment. It is your responsibility to know your coverage. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits paid and not paid by insurance.

Signed Date

PLEASE ANSWER ALL SECTIONS

When was your last eye exam?

Name of your past / current eye doctor?

Name of your personal physician?

What city?

Phone number?

Please list your medications: (including vitamins, creams, inhalers, sprays & injections)

Any allergies to medications? (please list)

The name and location of your pharmacy :

What brand of eye drops do you use?

Number of alcoholic drinks per day:

Number of cigarettes per day:

Are you a fomer smoker? Y N

Would you like to see without glasses?

- ○ Yes! I want to try contact lenses.
- ○ Yes! I want more information on LASIK.
- ○ Yes! I want more information on cataract surgery.
- ○ OTHER:

Do you experience any of the following:

- ○ Dry eyes?
- ○ Computer-related eyestrain?
- ○ Halos while driving at night?
- ○ Sensitivity to sunlight?
- ○ OTHER:

Do you enjoy any of these activities?

- ○ Camping / Hiking / Travel
- ○ Sailing / Fishing / Snow / Golf

Do you wear eye makeup? Yes / No

If yes, how do you remove it?

Any of these run in your family?

- □ High blood pressure
- □ Diabetes
- □ High cholesterol
- □ Glaucoma
- □ Macular Degeneration
- □ Retinal Disorder
- □ Cataracts
- □ Lazy Eye
- □ OTHER:

Do you have, experience or take?

Y	N		Y	N		Y	N	
□	□	Alcoholic abuse	□	□	Eye injury	□	□	Lupus
□	□	Accutane medication	□	□	Eye surgery	□	□	Menopause
□	□	Acne Rosacea	□	□	Feeling of something in eye(s)	□	□	Migraines
□	□	Asthma	□	□	Fatigue	□	□	Muscle pain
□	□	Asthma medication	□	□	Fever	□	□	Multiple Sclerosis
□	□	Blood disorder (Anemia / Leukemia)	□	□	Flashes of light	□	□	Numbness
□	□	Blurred vision	□	□	Floaters in your vision	□	□	Osteoarthritis
□	□	Bronchitis / Emphysema	□	□	Fluctuating vision	□	□	Pets (dogs or cats)
□	□	Bumps on eyelid margin(s)	□	□	Glaucoma	□	□	Recent weight loss / gain
□	□	Burning sensation in eye(s)	□	□	Glaucoma medication	□	□	Red eye(s)
□	□	Cancer	□	□	Gritty/sandy feeling in eye(s)	□	□	Retinal tear / detachment
□	□	Computer Eye Strain	□	□	Hay fever symptoms	□	□	Rheumatoid arthritis
□	□	Chronic obstructive pulmonary disease	□	□	Headaches	□	□	Sarcoidosis
□	□	Color blindness	□	□	Heart problems	□	□	Schizophrenia
□	□	Depression	□	□	Hepatitis	□	□	Sexually transmitted disease
□	□	Diabetes	□	□	High blood pressure	□	□	Sinus Infection
□	□	Diabetes when pregnant	□	□	HIV	□	□	Sleep apnea
□	□	Discharge from eye(s)	□	□	Hormonal Dysfunction	□	□	Sjogren's disease
□	□	Difficulty breathing	□	□	Itchy eye(s) or eyelid (s)	□	□	Skin problems
□	□	Digestive problems	□	□	Itchy nose	□	□	Stroke / Vascular Disease
□	□	Double vision	□	□	Joint pain	□	□	Swollen eye(s) or eyelid(s)
□	□	Drug abuse	□	□	Kidney problems	□	□	Thyroid problems
□	□	Dry eye(s)	□	□	Lazy eye or eyelid	□	□	Upper Respiratory Infection
□	□	Erectile dysfunction medication	□	□	Light sensitivity	□	□	Watering / Watery Eye(s)
			□	□	Liver problems	□	□	Watering / Watery Nose

Thank you for choosing our practice for your eye care. To ensure the privacy, respect and courtesy to our patients, we enforce the following acknowledgements and policies. Please do not hesitate if you have any questions.

Please Initial that you have read and agree to the following:	
	I have received the NOTICE OF PRIVACY PRACTICES information from Oakland Vision Center (available for download on our website & in person at the office).
	Payment of co-pays, deductibles or any balances not covered by insurance is due at the time of service. If you are being seen today, payment is due TODAY.
	We accept payment by cash, Visa and MasterCard. We do not accept checks.
	Please no food and drinks allowed in the reception area or in the doctor's office.
	Please turn your cell phones off (or to vibrate mode). No cell phones may be used in the reception area or in the doctor's office.
	This is a smoke-free zone. If at all possible, please avoid smoking before your appointment as the doctor is allergic.
	Restrooms are for patients with appointments only. No exceptions.
	We value your time. We try our very best to stay on schedule, although emergencies sometimes arise. If we are seriously delayed, we will try to notify you beforehand.
	If you are unable to make your appointment for any reason, please feel free to reschedule as soon as possible. This allows us time to give your slot to someone on our waiting list.
	DILATED PUPIL EXAM: Our comprehensive exam includes dilation to detect eye disease. Dilation with eye drops will last approximately 1-4 hours. You will experience sensitivity to light and blurry near vision. If you did not bring dark glasses, we will provide you with a disposable pair.
	REFRACTION IS NOT A COVERED BENEFIT: Most major medical plans do not cover the refraction portion of the examination. The refraction is how the doctor determines your glasses prescription or determines if your vision is changing. The refraction may be an out-of-pocket expense of $75.
	GLASSES: Glasses are custom-made for you and only you. There is no return or exchange on glasses (includes the lenses and frame). All our lenses and frames carry a 30 day to 1 year warranty against manufacturer's defect. Damage due to dropping your glasses, etc. is not covered. Payment in full is required before glasses can be ordered.
	CONTACT LENSES: Because contacts are a medical device, we follow a strict return / exchange policy. Please review The Contact Lens Agreement for detailed information.
	As required by law, all minors under the age of 18 must be accompanied by a parent / guardian to see the doctor.

~ We reserve the right to refuse service for any reason. ~

ALL CO-PAYS, DEDUCTIBLES AND PAYMENTS ARE DUE AT THE TIME OF SERVICE.

FOR MEDICARE PATIENTS ONLY: SIGNATURE ON FILE

I request payment of authorized Medicare benefits be made on my behalf to Oakland Vision Center for any services furnished me by the listed provider / supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. As Medicare Participating Providers, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (please print)	Provider, Name & Address
Patient's Signature	OAKLAND VISION CENTER 1960 Broadway Oakland CA 94612
Patient's Medicare #	

ALL OTHER INSURANCE PLANS / ASSIGNMENT OF BENEFITS

Patients with insurances please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans to Oakland Vision Center. I am hereby informed that my claim may be billed electronically to my Insurance Carrier or via the Internet.

I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request, to my insurance company, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. This assignment/consent will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations. For additional information on your insurance company's Patient Confidentiality Policy, please refer to their website and/or benefits provider.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY FOR PAYMENT OF FEES AND THAT THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL FEES.

Patient's / Parent's Signature Date