# Medical History Questionnaire

Name: _____ ☐ M ☐ F Birth Date: _____ Today's Date: _____

Address: _____ City: _____ Zip: _____

Email _____ Cell # _____

Occupation: _____ Employer: _____ Home #: _____ Work # _____

Name of Spouse: _____ Number of Children: ___ Referred by: _____ Social Security #: _____

## Insurance Information:

PATIENTS ARE RESPONSIBLE FOR OBTAINING THEIR INSURANCE BENEFIT INFORMATION. PLEASE INFORM THE FRONT DESK *AT THE TIME OF SERVICE* IF YOU HAVE DUAL COVERAGE.

PRIMARY VISION INS NAME: _____
IF INSURED IS DIFFERENT: Name of Insured _____
Date of Birth of Insured: _____
Member ID or SS# of Insured: _____
Relationship to Insured: self θ spouse θ dependant θ

MEDICAL INSURANCE NAME: _____ PPO HMO
IF INSURED IS DIFFERENT: Name of Insured _____
Phone # of Insured _____
Date of Birth of Insured: _____
Member ID or SS# of Insured: _____

IF SECONDARY VISION INS NAME: _____
IF INSURED IS DIFFERENT: Name of Insured _____
Date of Birth of Insured: _____
Member ID or SS# of Insured: _____
Relationship to Insured: self θ spouse θ dependant θ

Name of Medical Doctor: _____
Dr's Phone#: _____
Last check up: _____
IF SUPPLEMENTAL MEDICAL INS: _____ PPO HMO
Member ID or SS#: _____

I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of medical or vision benefits to Drs. Klem & Guarcello or their agents for services rendered. I understand that this is not a guarantee of payment, and that if the insurance company does not pay I will be responsible for payment of the unpaid balance. I also agree that my insurance co. may obtain or review my records.
**Patient (or Guardian) Signature** _____ **Print Name** _____ Date _____

## Medical History:

Do you have any known allergies to medications? ☐ yes ☐ no, if yes explain: _____
List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):
_____
_____
List all major injuries, surgeries and/or hospitalizations you have had: _____
_____

Are you pregnant/or nursing? ☐ yes ☐ no Have you had laser vision correction? ☐ yes ☐ no Are you interested? ☐ yes ☐ no
Do you wear glasses? ☐ yes ☐ no Do you wear computer glasses ☐ yes ☐ no Do you wear contact lenses? ☐ yes ☐ no
Reason for today's examination: _____

**Family History:** Please note any family history (yourself, parents or siblings or grandparents: living or deceased) of the following:

| DISEASE/CONDITION | YES | NO | ? | Myself | Mother | Father | Sibling | Grandparent |
|---|---|---|---|---|---|---|---|---|
| Blindness | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Cataract | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Crossed Eyes | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Glaucoma | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Macular Degeneration | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Retinal Detachment/Disease | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Arthritis | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Cancer | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Diabetes | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Heart Disease | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| High Blood Pressure | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Kidney Disease | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Lupus | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Thyroid Disease | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |

*Please turn this form over and complete side two*

## Social History

*This information is strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.* ☐ Yes, I would prefer to discuss my Social History information directly with the doctor.

Do you drive? ☐ yes ☐ no If yes, do you have visual difficulty when driving? ☐ yes ☐ no If yes, please describe:

_____

Do you use tobacco products? ☐ yes ☐ no If yes, type/amount/how long: _____
Do you drink alcohol? ☐ yes ☐ no If yes, type/amount/how long: _____
Do you use illegal drugs? ☐ yes ☐ no If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

## Review of Systems

Do you currently, or have you ever had any CHRONIC problems in the following areas:

| SYSTEM | YES | NO | ? |
|---|---|---|---|
| CONSTITUTIONAL | | | |
| Fever, Weight loss/gain | ☐ | ☐ | ☐ |
| INTEGUMENTARY (SKIN) | ☐ | ☐ | ☐ |
| NEUROLOGICAL | | | |
| Headaches | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| EYES | | | |
| Loss of Vision | ☐ | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | ☐ |
| Distorted Vision (halos) | ☐ | ☐ | ☐ |
| Loss of Side Vision | ☐ | ☐ | ☐ |
| Double Vision | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ |
| Sandy or Gritty Feeling | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ |
| Burning | ☐ | ☐ | ☐ |
| Foreign Body Sensation | ☐ | ☐ | ☐ |
| Excess Tearing/Watering | ☐ | ☐ | ☐ |
| Glare/Light Sensitivity | ☐ | ☐ | ☐ |
| Eye Pain or Soreness | ☐ | ☐ | ☐ |
| Infection of Eye or Lid | ☐ | ☐ | ☐ |
| Sties or Chalazion | ☐ | ☐ | ☐ |
| Flashes of Light | ☐ | ☐ | ☐ |
| Tired Eyes | ☐ | ☐ | ☐ |
| ENDOCRINE | | | |
| Thyroid/Other Glands | ☐ | ☐ | ☐ |

| | YES | NO | ? |
|---|---|---|---|
| EARS, NOSE, MOUTH, THROAT | | | |
| Allergies/Hay Fever | ☐ | ☐ | ☐ |
| Sinus | ☐ | ☐ | ☐ |
| Runny Nose | ☐ | ☐ | ☐ |
| Post-Nasal Drip | ☐ | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ | ☐ |
| Dry Throat/Mouth | ☐ | ☐ | ☐ |
| RESPIRATORY | | | |
| Asthma | ☐ | ☐ | ☐ |
| Chronic Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| VASCULAR/CARDIOVASCULAR | | | |
| Diabetes | ☐ | ☐ | ☐ |
| Heart Pain | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ | ☐ |
| GASTROINTESTINAL | | | |
| Diarrhea | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| GENITOURINARY | | | |
| Genitals/Kidney/Bladder | ☐ | ☐ | ☐ |
| BONES/JOINTS/MUSCLES | | | |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Muscle Pain | ☐ | ☐ | ☐ |
| Joint Pain | ☐ | ☐ | ☐ |
| LYMPHATIC/HEMATOLOGIC | | | |
| Anemia | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ |
| ALLERGIC/IMMUNOLOGIC | ☐ | ☐ | ☐ |
| PSYCHIATRIC | ☐ | ☐ | ☐ |

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____
_____
_____
_____

_____ _____
Patient Signature Date

It is becoming the standard of care to photodocument the back of the eye, for baseline purposes, even if your eyes are healthy. We offer a set of high quality digital retinal images or an eye wellness OCT-scan. The best care is to have both procedures. The retinal image is like a picture of the outside of your house and the eye wellness scan is like a floor plan of your house.

1) Digital Retinal Photography: Produces an image of internal eye health. We can observe, magnify and demonstrate the internal anatomy. The fee is $38.

2) OCT Wellness Scan: This imaging produces an image of retinal layers and thickness. With the OCT we can see minute swelling or thinning of the retina. The fee is $45.

3) The fee for both is $48.

Both are very important for monitoring the health of your eyes in the future and the Doctors recommend both.

If you have diabetes, hypertension, elevated cholesterol, headaches, flashing lights, floaters, blurred vision or macular degeneration you should have these images done annually. The standard of care for patients with diabetes or pre diabetes, is to have these scans done yearly. We send a letter to your Primary Care Physician to keep them up to date about the health of your eyes. Even in healthy eyes, a baseline image is recommended.

☐ I **DO want BOTH** eye wellness & retinal imaging ($48)

☐ I **DO want ONLY** the recommended retinal imaging ($38)

☐ I **DO want ONLY** the eye wellness scan ($45)

☐ I want to talk with the doctor about these tests

☐ I **DO NOT want** the retinal imaging nor the eye wellness scan

Patient name:_____

Date:_____

## CONSENT TO DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Patient Name: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Patient Phone: _____

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. We have a comprehensive Notice of Privacy Practices that describes these uses in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure 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. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of claims to third-party payors or insurers for claims review, determination of benefits and payment, our submission of your health information to auditors hired by third-party payors and insurers, among 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 your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated 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 restriction.

With your signature below you also give your permission to release information to the following people whom you identify:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

***I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.***

Patient Signature: _____ Date: _____

*If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of authority to sign this form.*

Relationship to Patient: _____

Name: _____

Source of Authority: _____

# RETURN AND CANCELLATION POLICY ON PRESCRIPTION EYEWEAR

**FRAMES:** All frames are warranted against manufacturer defects only for a period of one year from date of purchase. Manufacturer guidelines will apply. Scratches from obvious abuse are not considered defects. If you Damage/Break frame, we can replace it at 50% off within 1 yr from date of purchase.

**PRESCRIPTION LENSES:** Lenses will be made and inspected to the specification of the prescription given and with the material and option you have selected. If the lens fails as a result of a manufacturers defect for a period of one year from purchase date we will replace with the identical item in the original prescription at no charge to you.

**ANTI-REFLECTION & SCRATCH COATINGS:** Are warranted with full lens replacement with the original lens material and prescription at no cost to the patient, one time, within one year from the date of purchase for coating failure including hairline scratches, peeling, and crazing.

**NON-ADAPT POLICY:** If, within 60 days, you are not satisfied with lens performance, they may be exchanged for another lens type, of your choosing, up to the original value. If the new lens chosen is of greater value only the additional amount is charged. NO REFUNDS OR RETURNS.

**CANCELLATION POLICY:** Jobs are ordered immediately after your visit and the laboratory begins the job as soon as they received the order. All costs incurred once a prescription has been started at the lab, whether or not completed, are the patient's responsibility and are not eligible for a refund.

**IF YOU HAVE A PROBLEM WITH YOUR PRESCRIPTION:** Rechecks on prescriptions within 60 days of purchase are performed at no charge. If something seems wrong, come in as soon as possible so we can correct any problem. Within the 60 days period remakes on lenses are at no charge. There are no exceptions to the 60 day period so please come to have your eyewear dispensed as soon as you are notified.

**OUTSIDE DR. PRESCIPTION CHANGES:** One Drs Change at no charge will be honored for a period of 60 days from the date of purchase. Cost associated with changes other than the prescription will be the responsibility of the patient.

**NON-PRESCRIPTION:** Items are not refundable and, are warranted against manufacturer defect only for a period of one year from purchase date and will be replaced with the same or like item. Non-defective product returned for credit or exchange must be received in original condition within 10 days of purchase date.

**Initial:** _____

# Paul R. Gollender, O.D., A California Optometric Corporation

## Contact Lens Policies and Informed Consent

**Welcome** to the world of contact lens wearers. If you aren't already a member, you will hopefully soon join the ranks of 30 million other American contact lens wearers. Contacts offer a great alternative for glasses and are worn by everyone of all ages.

**Contact Lens Services** are separate services from general exam services and require additional tests, training, time and decision making to arrive at a prescription (which is not the same as an eyeglass prescription). Determination of successful wear and prescription sometimes is a complex problem that only your doctor is qualified to do. Not everyone of every eye can wear contact lenses successfully. Complications can occur both minor and major, ranging from persistent redness, dry eyes, and irritation to corneal infection, ulceration, scarring, pain and even permanent loss of good vision. Poor night vision and reduction of depth perception are sometimes reported.

**Contact Lens Professional Fees** range in prices from **$95.00** (for simple renewal) to **$1400** (or corneal refractive therapy) and are **covered for 60 days after the initial consultation of 45 days after the finalized prescription.** Problems occurring after that are charged on a per office visit. Please present your medical insurance card in addition to your vision card at the initial consultation. If, by chance you do develop a problem, we are happy to take care of you but we are not providers for every insurance.

Contact Lens Material Fees are determined by the actual cost of the lens, which vary by prescription and manufacturer.

Other Policies:

- Minors under the age of 18 will need parental permission and consent.
- All contact lens wearers should have back-up glasses in case of an infection or loss of contacts.
- Monovision contact lens wearers are encouraged to get compensatory driving glasses for optimal safe driving.
- Dry eye and allergy patients may not be able to wear their lenses as long, or may be required to change their contacts more frequently, or they may need to go on an oral and / or topical medications, necessitating additional non-covered office visits.
- Colored contacts are non-refundable.
- CRT (CORNEAL REFRACTIVE THERAPY) is not covered by vision or medical insurance.
- Cancellations: in the event that the patient changes his or her mind after the fitting process has begun, the patient will be responsible for 75% of the professional fees and any of the opened product.
- We honor valid outside contact lens prescriptions that are dated within the last 12 months by either an optometrist or ophthalmologist.
- Patients that have had a general eye exam in the last 12 months but have no valid contacts lens prescription will be charged our regular contact lens fitting rate plus a **$69.00** refraction charge.

Informed Consent:

I, _____, have read the above policies and I understand the risks and alternatives to contact lens wear for my particular case.

Date:_____Patient (or Guardian) Signature:_____