SAN DIMAS
—OPTOMETRY—

Suzan Burmayan, O.D.

WELCOME TO SAN DIMAS OPTOMETRY

DATE: ____ /____ /____

PATIENT INFORMATION

PATIENT NAME: _____
LAST
_____ _____
FIRST M.I.

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME #: (_____) _____ - _____ CELL #: (_____) _____ - _____

AGE: _____ DATE OF BIRTH: ____ / ____ / ____ SEX: ☐ M ☐ F

OCCUPATION: _____

SOCIAL SECURITY #: _____ / _____ / _____

EMPLOYER/SCHOOL: _____

RESPONSIBLE PARTY: ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER _____

WORK #: (_____) _____ - _____

NAME: _____ DATE OF BIRTH: _____/_____/_____

E-MAIL: _____

(Parent/Guardian) SOCIAL SECURITY #: ___-__-____

HOBBIES:_____

How did you hear about us? ☐ Google ☐ Insurance Listing ☐ Yelp ☐ Friend/Relative _____ ☐ Other _____

EYE HEALTH HISTORY

Date of Last Eye Exam: _____

REASON FOR VISIT TODAY: _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Reading/Computer ☐ Driving/Distance

Do you wear contacts or have in the past? ☐ Yes ☐ No

What type/brand? _____

Describe any problems with the contacts:

_____

Current Eye Drops (please list):

_____

Are you interested

☐ Contact Lenses ☐ Laser Surgery

Do you or have you had any of the following:

☐ Amblyopia (lazy eye)
☐ Blurred Distance Vision
☐ Blurred Near Vision
☐ Cataracts
☐ Color Vision Defect
☐ Crossed Eyes (Strabismus)
☐ Double Vision
☐ Dry Eyes
☐ Eye Infection
☐ Eye Strain
☐ Eye Injury: Type? _____ When? _____
☐ Eye Surgery: Type? _____ When? _____
☐ Other _____
☐ Flashes of light
☐ Floaters/spots
☐ Glaucoma
☐ Headaches / Migraines
☐ Itchy Eyes
☐ Macular Degeneration
☐ Red Eyes
☐ Retinal Detachment
☐ Watery Eyes

MEDICAL HISTORY

Date of Last Physical: _____ **Name of Primary Care Physician**: _____ **PCP Phone Numbe**r:_____

Do you currently, or have you ever had any of these conditions? If yes, please mark the box and describe if necessary.

☐ Fever, Weight Loss/Gain _____
☐ Skin Conditions _____
☐ Cancer _____
☐ Seizures _____
☐ Thyroid/other gland disorder _____
☐ Allergies/HayFever _____
☐ Asthma _____
☐ Sinus Problems _____
☐ Chronic Bronchitis _____
☐ Emphysema _____
☐ Diabetes: ☐ Type I ☐ Type2
Last Blood Sugar _____
☐ Heart Condition _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Gastrointestinal _____
☐ Kidney Disorders _____
☐ Arthritis/ Rheumatoid_____
☐ Muscle/ Joint Pain _____
☐ Anemia / Bleeding Problems _____
☐ Psychiatric Problems _____
☐ Pregnant/ Nursing_____
☐ Other _____

Current Medications: _____

_____

_____

_____

Allergies to Medications: _____

_____

_____

_____

Do you use tobacco products? ☐ YES ☐ NO Do you drink alcohol? ☐ YES ☐ NO ☐ Occasionally Do you use recreational drugs? ☐ YES ☐ NO

FAMILY HISTORY

Does any family member (parents, grandparents, siblings, children; living or deceased) have the following conditions? If yes, please mark box and indicate which family member.

- ☐ Amblyopia (lazy eye) _____
- ☐ Blindness _____
- ☐ Cataract _____
- ☐ Color Vision Defect _____
- ☐ Crossed Eyes (Strabismus) _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Arthritis _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart Condition _____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Lupus _____
- ☐ Stroke_____
- ☐ Thyroid Disorder _____
- ☐ Other _____

PRIMARY VISION INSURANCE

IF INSURED IS OTHER THAN SELF, LIST **INSURED** INFORMATION:

☐ VSP ☐ EyeMed ☐ Medi-Cal ☐ Medicare ☐ None ☐ Other _____

NAME: _____ _____ _____ RELATIONSHIP: _____
LAST FIRST MI

DATE OF BIRTH: _____/_____/_____ SS #: _____/_____/_____ MEMBER ID #: _____

IS PATIENT COVERED UNDER ADDITIONAL VISION INSURANCE? ☐ YES ☐ NO

☐ VSP ☐ EyeMed ☐ Medi-Cal ☐ Medicare ☐ None ☐ Other _____

NAME: _____ _____ _____ RELATIONSHIP: _____
LAST FIRST MI

DATE OF BIRTH: _____/_____/_____ SS #: _____/_____/_____ MEMBER ID #: _____

PRIMARY MEDICAL INSURANCE

☐ HMO ☐ PPO ☐ Kaiser ☐ OTHER: _____

SUBSCRIBER'S NAME:_____ _____ _____ INSURANCE COMPANY NAME:_____
LAST FIRST MI

MEMBER ID #: _____ GROUP #: _____ PHONE # : (____)_____-_____

PRACTICE POLICIES & INSURANCE ASSIGNMENT AND RELEASE AUTHORIZATION

☐ I certify that I, and/or my dependents, have coverage with the above named insurance(s) and assign my insurance benefits payable to **San Dimas Optometry**. I understand that I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature** on all insurance submissions and consent to the use and disclosure of my health care information to the above-named Insurance Company(ies) for the purpose of obtaining payment for services and determining insurance benefits.

☐ Orders for ophthalmic products and services are custom to each patient; therefore, **ALL SALES ARE FINAL**. A $50 charge will be applied to your account for any disputed Credit Card or Care Credit charges, regardless of the outcome determined by the credit card or Merchant Services Company.

☐ Returns or exchanges for **contact lens boxes** that are in resalable condition require approval and are subject to a 15% restocking fee.

☐ Contact lens prescriptions require a yearly evaluation, which is **in addition to** an eyeglass exam. The evaluation fees range from **$89 - $189** depending on the complexity of your prescription and insurance. This fee includes one pair of trial contact lenses and any necessary follow-up visits. The evaluation fee is **due at the time of service.**
Additional fees may apply if:

1. Follow-up care is not completed within **three months** from the evaluation date.
2. The Doctor needs to refit to a different prescription or brand.
3. The Doctor needs to treat related infections and/or complications.

I agree with the policies above and certify that the given information is correct to the best of my knowledge. **My signature below indicates that I understand and accept all office policies.**

_____ _____ _____
SIGNATURE (Patient or Guardian) **DATE** **Doctor's Review Initial**

Thank you for your time!