FOOTHILL
OPTOMETRIC CENTER

Foothill Optometric Center
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(909) 899-0026

Welcome to Our Office

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

Full Name (Mr./Mrs./Ms./Miss/Dr.) _____ Today's date _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed

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

Medical Insurance_____ How will you settle your account today?

Do you participate in a flexible spending account? Y N ❑ Debit Card ❑ Cash ❑ 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) EyeMed Other _____

If patient is not the member, please provide the following <u>member</u> information: Name _____

Date of birth _____ Social Security number _____

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

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

Substance Use

Do you use: ❑ Alcohol ❑ Cigarettes/Tobacco

❑ Other, please list.

_____

_____

_____

_____

Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)

_____

_____

_____

_____

_____

Are you allergic to any medicines? Y N (If yes, please list)

_____

_____

_____

_____

Please complete the second page...

Welcome to Our Office, *continued*

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) _____

_____

How did you *first* hear about our office?

- ❑ Family, friend, or co-worker. Who? _____
- ❑ Doctor Referral. Who? _____
- ❑ Eye care plan directory. _____
- ❑ Yellow pages. Which directory? _____
- ❑ Internet. Which website? _____
- ❑ Other. 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
Will you be ordering new glasses today?	Y	N	Only if there is a change.

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. Justin T. Abo & Dr. Larissa A. Murakami-Abo's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, www.visionsource-foothill.com.

Patient name _____ Today's Date _____

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

Thank You!

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Optomap Digital Eye Imaging Technology

Foothill Optometric Center is pleased to offer you and your family the most highly advanced technology available in eye disease detection, the Optomap Digital Retinal Imaging. This digital imaging system allows us to thoroughly evaluate your internal eye health with dramatically improved precision that includes a depth in the retina not seen with regular dilation.

Our Doctors are concerned about retinal diseases such as macular degeneration, glaucoma, retinal detachments, and diabetic retinopathy; all which can lead to partial loss of vision or blindness. Additionally, systemic diseases such as diabetes and high blood pressure can be detected with a retinal examination. Eye exams with retinal evaluations can help you safeguard both your eyesight and general health.

Our Doctors Recommend Optomap for the Following Reasons:

Optomap Retinal Imaging Provides:

- The ability to show you your retinal images today, during your exam.
- An In-Depth 3D view of your retinal layers (where diseases can start).
- A permanent record for your medical records, which gives your doctor a comparison for diagnosing and tracking retinal eye disease annually.

Optomap Retinal Imaging is:

- Fast, easy, and comfortable.
- Patient Friendly.
- ***Eliminates the need to be dilated, in most cases.***

Our doctors are committed to providing you and your family the highest standards of eye care available and recommend Optomap annually. With an annual Optomap, our doctors can track your eye health for concerns, comparison, and treatments. Because this technology is new, it is not covered by insurance and there is a **$39.00** fee for this procedure. *(Please advise staff if you have a history of epilepsy.)*

_____ I elect to have an Optomap Digital Retinal Image of my retina.

_____ **I DECLINE** the Optomap Retinal Imaging and am choosing to be dilated today.

_____ **I DECLINE** BOTH the Optomap and dilation. I understand that the potential for partial or total loss of vision may exist due to undetected eye disease. I also understand it is my responsibility to schedule a dilated fundus exam.

Signature: _____ Date:_____
Patient / Parent or Guardian if patient is a minor