Welcome

personal information

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Male ☐ Female

Marital Status: single married divorced widowed

Patient's Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security #(last four digits optional): _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Mobile Phone #: (_____)_____ Home Phone #: (_____)_____

Work Phone#: _____ Email: _____

Occupation: _____ Employer: _____

Reason for visit?: vision exam medical eye exam glasses contact lenses

Do you currently wear glasses? Yes No Do you currently wear contact lenses? Yes No

Date of Last exam: _____ Soft RGP Hybrid Scleral

Emergency Contact Name: _____ Relationship:_____

Phone#: (_____)_____

health insurance information

Vision Insurance Company: _____

Name of Primary Insured: _____

Primary Date of Birth: _____ Primary Social Security #: _____

Member ID #: _____ Group #: _____

Relationship to Insured: ☐ self ☐ spouse ☐ child ☐ other

Patient Status: ☐ Single ☐ Married ☐ Other ☐ Full-time student ☐ Part-time student

Medical Insurance Company: _____

Name of Primary Insured: _____

Primary Date of Birth: _____ Primary Social Security #: _____

Member ID #: _____ Group #: _____

Relationship to Insured: ☐ self ☐ spouse ☐ child ☐ other

Patient Status: ☐ Single ☐ Married ☐ Other ☐ Full-time student ☐ Part-time student

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Billing Policy:

Vision insurance will cover routine evaluations of the eye health and vision. It helps to pay for eyeglasses or contact lenses.

Medical insurance coverage applies when there is a medical diagnosis/condition of the eyes that cannot be treated alone with a spectacle/contact lens prescription (such as diabetic retinopathy, glaucoma, cataracts, eye infection, etc).

I, hereby, authorize the office of Dr. Julie Cho to file my claim with the appropriate insurance based on the reason/result of my examination.

X initial: _____

Office Policy:

- Co-Payments, Co-Insurance, Deductibles, Non-covered services and Items exceeding your insurance maximum are due at the time of service.
- Patient is responsible for any amount not covered by insurance. Payment is due within 60days from the time of service.
- There are NO REFUNDS on services and/or spectacle orders. If patient is not satisfy with glasses ordered, there is one time ReDo at no cost to patient within 60 days of the purchase date.
- Any previous balance must be paid off before any further service.
- All purchases must be paid in full before or at the time they are dispensed.
- No shows and last minute cancellations within a 24 hour period will be charged an office fee of $35.
- All spectacle/contact lens orders require at least 50% deposit before the order is placed.
- All Warranty/replacement orders will require Shipping and Handling Fee $25.
- Any Orders not picked up within 6 months of purchase will be discarded and the deposit on the order will not be refunded.

X Initial_____

Acknowledgement of Receipt:

I acknowledge that I have read and understood Notice of Privacy Practice and have declined a copy of Notice of Privacy Practices.

_____ _____

Patient Signature (Parent/Guardian if under 18) **Date**

Guardian Name/relationship to patient:_____(If guardian signed)

medical history

Name of Physician: _____ Phone #: (____) _____

Medical Conditions: _____

Any medications?: _____ Any allergies?: _____

Do you smoke? : Y / N if yes, ☐ Occasionally ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack/day

Do you drink?: Y / N if yes, ☐ Occasionally ☐ 1 per/day ☐ 2/3 per/day ☐ 4+/day

Your History:

☐ Cataracts ☐ Glaucoma ☐ Diabetes ☐ Macular Degeneration

☐ Infection of Eye/Lid ☐ Double Vision ☐ Headaches ☐ Itching/Redness

☐ Color Blindness ☐ Amblyopia (Lazy Eye) ☐ Loss of Vision ☐ High Blood Pressure

☐ LASIK/RK/PRK

Family History (specify family member):

☐ Cataracts ☐ Macular Degeneration ☐ High Blood Pressure ☐ Lupus

☐ Blindness ☐ Retinal Detachment ☐ Arthritis ☐ Diabetes

☐ Color Blindness ☐ Amblyopia (Lazy Eye) ☐ Stroke ☐ Thyroid Disease

☐ Heart Disease ☐ Kidney Disease ☐ Cancer (where:_____)

☐ Other _____ Surgeries (with dates if possible)

Current Medications (Rx and OTC. Give dosage if possible)_____

_____

Allergies (General)_____

Allergies (Medications) _____