Milpitas Family EyeCare

Dr. David Schymeinsky O.D. & Dr. George Contos O.D.
462 East Calaveras Blvd. Milpitas, CA 95035
Ph: (408) 262-4178 | Fax: (408) 262-5351
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Welcome To Our Office

We are happy you have chosen our office for your vision care. It is our philosophy to provide you with the highest quality & up to date examination techniques. Please complete this form to assist us in evaluating your vision needs.

Patient Information Today's Date: _____

Name: (Mr. / Mrs. / Ms. / Miss) _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Work / Cel. #: _____ Email: _____
In case of Emergency, Contact Name: _____ Ph. #: _____ Relation to patient: _____
Occupation: _____ Employer: _____ SS# _____
Whom may we thank for referring you? _____ Relative(s) who also come here? _____

Insurance Information (Please provide *both* vision & major medical insurance cards to the front desk clerk to be copied for your records)
Primary Member (if different, from above): _____ SS#: _____ DOB: _____
Major Medical Insurance Name: _____ Ph. #: _____ ID#: _____
Primary care physician: _____ Ph #: _____ Fax #: _____ City: _____

Patient History
What is the main reason for today's visit? Annual Exam / Contact Lens / Other _____
Last eye exam: _____ How old are your present glasses? _____ Contact Lenses? _____
When do you use your glasses? ___ Constantly ___ Reading only ___Distance only ___ Rarely use
When do you use your contacts? ___ Constantly ___ Reading only ___Distance only ___ Rarely use
Type & brand of current contact lenses? _____ Average wear time ____ hrs Today's wear time ___ hrs
What solutions do you currently use? _____ Are you interested in Laser Surgery? YES / NO
Please rate on a scale of 1-10 (1 being POOR & 10 being EXCELLENT):
Lens Comfort: Right ____ Left ____ Distance Vision: Right ____ Left ____ Near Vision: Right ____ Left ____
If not a contact lens wearer yet, are you interested in getting contact lens at this time? YES* / NO
If current contact lenses are not working out, are you interested in trying out different designs or brands? YES* / NO

Have you ever had:

Current Condition
Y / N Light sensitivity
Y / N Blurred distance vision with your current glasses/contacts
Y / N Blurred near vision with your current glasses/contacts
Y / N Blurred distance vision without your current glasses/contacts
Y / N Blurred near vision without your current glasses/contacts
Y / N Headaches
Y / N Uncomfortable vision OR tired eyes
Y / N Dry eyes
Y / N Distorted vision
Y / N Double vision
Y / N Usually red or irritated eyes

Past Eye Health History
Y / N Intermittent loss of vision
Y / N Eye injury
Y / N Severe head injury
Y / N Eye infection
Y / N Halos or rainbows near lights
Y / N Crossed/Wandering/Lazy eye
Y / N Glaucoma
Y / N Cataract
Y / N Retinal Disease
Y / N Flashes of light
Y / N Eye surgery

General Health Condition
Y / N Heart Disease
Y / N High blood pressure
Y / N Allergies
Y / N Arthritis
Y / N Diabetes: for how many years? ____
Y / N Recent physical exam Date: _____ Physician: _____
Medication(s): _____ Reactions_____

Family History
Y / N Glaucoma
Y / N Cataract
Y / N Retinal disease
Y / N Crossed/Wandering/Lazy eye
Y / N High blood pressure
Y / N Diabetes
Y / N Any Inherited Disease _____

**Please be advised that contact lens services fees may apply and vary depending on your necessities, prescriptions, and types of contact lens being prescribed. Fees include: fitting, evaluation, trial pair(s), training, and 1 follow up appointment. The second or more follow up appointment(s) needed will be additional charge(s).*
I agree to receive contact lens services & pay applicable fee(s). Signature: _____ Date: _____
I received a copy of the Notice of Privacy Practices for this office. Signature: _____ Date: _____

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INSURANCE & BILLING POLICIES

Your insurance coverage is a contract between your insurance company and you. You are responsible for all the amounts not covered by your insurance policy. We, as a courtesy, bill your insurance carrier on your behalf. Please provide any and all necessary information to help aid in this process.

- We reserve the right to discontinue billing your insurance carrier and look directly to you for payment.
- If your insurance carrier does not pay within 60 days, then we will expect payment from you. All accounts with an outstanding balance after 60 days may be subject to a monthly finance charge of 1.5%.
- We will bill generally after each service of treatment.
- If there is secondary insurance coverage, we again, as a courtesy will bill your secondary insurance carrier for you. Again, if payment is not received within 60 days after billing, payment will be expected from you.
- We require payment of the estimated percentage that your insurance DOES NOT cover at the time services are rendered.
- You are expected to sign all the necessary forms required to notify your carrier to pay our office directly. In the even the carrier pays the patient directly, full payment is due at the time services are rendered.
- We will make every attempt to collect from your insurance company for you. However, all disputes regarding payment are between YOU and YOUR INSURANCE COMPANY. <u>YOU ARE RESPONSIBLE FOR YOUR ENTIRE BILL AT ALL TIMES.</u>
- A service charge of $25 will be charged for all returned checks.
- Missed, “no show”, or cancelled appointments greatly affect the office schedule, and it is our policy to charge a $35 fee for missed appointments. Your insurance is not liable for these charges. Please notify us 24 hours prior to your appointment to avoid the fee.

No insurance: All charges must be paid in full at the time services are rendered.

<u>I HAVE READ AND AGREE WITH ALL THE ABOVE POLICIES</u>

Name: _____ Relation to patient (if applicable): _____
Signature: _____ Date: _____