Account # _____ Appointment Date: _____ Time: _____

Welcome to Our Office!

Patient Information for Medical Records - Hidden Valley Eye Associates

Please Print Clearly Please Use Black Ink

Patient Name

Last:		First:		Middle Initial:		Phone:	

Mailing Address

Street:		City:		State:		Zip Code:			
Birthdate:		Soc. Sec. #		Driver's Lic. #		○ Male	◉ Female		
Email:		Cell:		Texting Ok:	○ Yes	◉ No			
Employer Name:		City:		Work Phone:					
Occupation:		Age:							
Primary Care Physician:		Maritial Status:	○ Married	○ Single	○ Widowed	◉ Divorced			
Spouse's Name:		Soc. Sec. #		Birthdate:					
Spouse's Employer:		City:		Work Phone:					

Insurance Information for Responsible Person or Policy Holder

Last Name:		First Name:		Middle Initial:	

Home Address

Street:		City:		State:		Zip Code:	
Relationship to Patient:		Home Phone:		Work Phone:			
Driver's Lic. #		Birthdate:		Soc. Sec. #		○ Male	○ Female
Occupation:		Age:					
Primary Insurance:		Policy or ID#:					
Seconary Insurance:		Policy or ID#:					
Vision Insurance:		3rd or other Ins. Info.:					
Referring Doctor:							
Other than your Doctor, how did you hear about us?							

I hereby authorize my doctor to provide information to my insurance regarding any illness or treatment. I understand that I am responsible for any charges, balances, or co-payments not covered by my insurance. I hereby assign my doctor all money to which I am or my heirs are entitled for medical services rendered.

I also understand that drops may be put into my eyes and that these drops may temporarily blur my vision for up to 48 hours. I understand that driving, reading, and other activities may be affected. Arrangements for a driver may have to be made.

Responsible Party Signature: _____ Date: _____

Phone: (760) 746-3937 Fax: (760) 746-3991 www.hiddenvalleyeye.com

Patient's Name: _____ Date: _____

What problem/reason brought you to the eye doctor? _____

Name of general physician: _____

EYE HISTORY

Have you ever had:

○ Yes	○ No	**Eye injury**
○ Yes	○ No	**Cataract**
○ Yes	○ No	**Glaucoma**
○ Yes	○ No	**Macular degeneration**
○ Yes	○ No	**Contact lenses**
○ Yes	○ No	**Lazy eye**
○ Yes	○ No	**Decreased vision**
○ Yes	○ No	**Poor side vision**
○ Yes	○ No	**Poor night vision**
○ Yes	○ No	**Poor color vision**
○ Yes	○ No	**Halos around lights**
○ Yes	○ No	**Problems with glare**
○ Yes	○ No	**Red eye**
○ Yes	○ No	**Dryness**
○ Yes	○ No	**Itching**
○ Yes	○ No	**Mattering/Crusting**
○ Yes	○ No	**Tearing**
○ Yes	○ No	**Double vision**
○ Yes	○ No	**Floaters**
○ Yes	○ No	**Flashing lights**

○ Yes ○ No **Eye surgery (if yes, what type)**

_____

_____

_____

_____

Date of last eye exam: _____

Name and address of last eye doctor:

_____

_____

_____

Please list any eye drops you are using:

_____

_____

What is (was, if retired) your occupation:

_____

MEDICAL HISTORY

Have you ever had:

○ Yes	◉ No	**Arthritis**
○ Yes	◉ No	**Heart disease**
◉ Yes	○ No	**Diabetes**
○ Yes	◉ No	**Thyroid disease**
◉ Yes	○ No	**High blood pressure**
◉ Yes	○ No	**Lung disease**
◉ Yes	○ No	**Neurologic disease**
○ Yes	○ No	**Liver disease**
○ Yes	○ No	**Kidney disease**

○ Yes ○ No **Allergies (if yes, to what)**

_____

_____

_____

_____

Please list all medications you are presently taking:

_____

_____

_____

_____

_____

_____

_____

Has anyone in your family had:

Blindness (any type):	○ Yes	○ No
Glaucoma:	○ Yes	○ No
Cataract:	○ Yes	○ No
Macular degeneration:	○ Yes	○ No
Retinal detachment:	○ Yes	○ No
Diabetes:	○ Yes	○ No
Do you smoke?	○ Yes	○ No
Have you smoked for more than 1 year?	○ Yes	○ No
Do you drink more than 4 drinks per week?	○ Yes	○ No

Sign below when you have completed this form to the best of your knowledge and are satisfied you understand its contents:

_____ _____ _____

Patient or Responsible Party Signature | Relationship to Patient | Date

Hidden Valley Eye Associates

Arvind Saini, M.D. **Howard Krauz, M.D** **Jean-Paul Abboud, M.D.** **Gina Grasso, O.D.**

1955 Citracado Parkway #301 Escondido, CA 92029

You will be receiving a comprehensive exam of your eyes which includes:

- A thorough medical evaluation of your eyes with dilated pupils
- Internal and external exam, papillary reflexes, ocular motility
- Tonometry (which determines the pressure of the eyes for possible glaucoma)
- Visual field screening (a screening test of your peripheral vision).

If you are seeing the optometrist you may also receive:

- A test for determining your eyeglass prescription (also known as a refraction)

The refraction portion of the exam is specifically excluded from most medical insurance, including Medicare and many secondary providers.
A refraction does not correct any eye disease and is unrelated to the health of the eye, therefore many insurance providers classify refractions as 'not medically necessary' and they exclude them from your insurance coverage.
There are many 'supplemental' vision insurance plans such as Vision Service Plan, Medical Eye Services and Secure Horizons, which will pay for both the comprehensive exam and the refraction. If you have a refraction done you will receive a copy of your eyeglass prescription.
Since there are so many insurance companies and each offer many different plans, it is impossible for us to know if your plan will cover your visit. We recommend that you check with your insurance company before your appointment if you have any questions about your coverage.

The cost for the refraction is $45.00 and is due and payable by you on the day of the appointment.
If you do not have a medical diagnosis, you may be responsible for the total cost of the comprehensive exam as well which can vary from $157 - $181. We want to make sure that you are completely informed about the exam you will be receiving today. If you have any questions, please feel free to ask. Please also be aware that exams for contact lenses, laser surgery, and pediatric eye exams often require additional, more specialized tests and may incur additional charges.

_____ _____
Patient or Guardian Signature Date

I ACKNOWLEDGE THAT I AM AWARE OF THE PRIVACTY PRACTICES FOR HIDDEN VALLEY EYE ASSOCIATES, RELATIVE TO HIPPA.

_____ _____
Patient or Guardian Signature Date