



Eye Care & Optical Boutique

Dr. Ioana M. Swikard
Optometric Physician

Privacy notice: This office's privacy practices are in accord with HIPPA regulations. You may obtain a copy of our privacy practice at any visit. Your signature here indicates that you have been advised of the availability of this information.

Please sign _____

Patient Questionnaire

Date _____

Name Mr / Mrs / Ms / Miss (last) _____ (first) _____ (mi) _____

Date of Birth _____ Age _____ Sex: M F

Mailing address _____ City _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

SS# _____ E-mail _____ @ _____ (For office communication only)

Single Married Significant other name _____

Parent name if patient is under 18 _____

Occupation _____ Employer _____

Vision insurance Y / N

Name of Insurance _____ Insurance Phone # _____

Insurance Address: _____ Group Name: _____

Group Number _____ Policy Number: _____ Member ID # _____

Insured name _____ Insured SS# _____ Insured DOB: ___/___/___ Insured Gender: M/F

Patient Relationship to Insured: Self / Spouse / Child / Other _____

Medical insurance

Name of Insurance _____ Insurance Phone # _____

Insurance Address: _____ Group Name: _____

Group Number _____ Policy Number: _____ Member ID # _____

Insured name _____ Insured SS# _____ Insured DOB: ___/___/___ Insured Gender: M/F

Patient Relationship to Insured: Self / Spouse / Child / Other _____

How did you first hear about our office?

Yellow Pages Internet Insurance Community event Walk-in Friend/ relative...Who? _____

PhysicianWho? _____

Eye Exam History

Date of last eye exam _____ Dilated Y / N Name of last eye Doctor _____

What is the major purpose of your visit? _____

Medical Information

Please check all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nerves | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Cholesterol | |

Current Medications: _____

Allergies to Medication: _____

Please complete information on the back ►

Family Medical History

| | | | | | |
|----------------------|-------|----------------|---------------------|-------|----------------|
| Cataracts | Y / N | Relation _____ | Diabetes | Y / N | Relation _____ |
| Glaucoma | Y / N | Relation _____ | High Blood Pressure | Y / N | Relation _____ |
| Macular Degeneration | Y / N | Relation _____ | Other _____ | | Relation _____ |
| Retinal Detachment | Y / N | Relation _____ | | | |

General Information

Do you wear glasses? Y / N

Are glasses for distance? Y / N

Are glasses for computer? Y / N

Are glasses for reading? Y / N

Do you wear contacts? Y / N

What type? _____

DO YOU EXPERIENCE? Check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Burning eyes | <input type="checkbox"/> Gritty eyes | <input type="checkbox"/> Blurry computer |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Floaters | <input type="checkbox"/> Glare or reflections |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Uncomfortable glasses | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Blurry distance vision | |
| <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Blurry reading vision | |

Visual Needs

Are you planning to get new glasses today? Yes No Only if Rx change

Are you planning to get new contacts today? Yes No Only if Rx change

Are you interested in a Lasik consultation today? Yes No At a later date

DO YOU... Check Box if answer is YES

- | | |
|--|---|
| <input type="checkbox"/> Work at a computer for long periods of time? | <input type="checkbox"/> Ever find need for prescription sunglasses? |
| <input type="checkbox"/> Have only one pair of glasses? | <input type="checkbox"/> Have problems with glare or reflections (ex: night driving)? |
| <input type="checkbox"/> Want information on thinner , lighter lenses? | <input type="checkbox"/> Do work requiring safety glasses? |
| <input type="checkbox"/> Wear bifocals? | <input type="checkbox"/> Participate in sports activities? What? _____ |
| <input type="checkbox"/> Want information on lineless bifocals? | <input type="checkbox"/> Want information about vision correction without surgery? |
| <input type="checkbox"/> Prefer not to wear glasses at times? | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Spend a lot of time outdoors? | |

I understand that if my insurance eligibility cannot be verified, or if my insurance does not pay the amount due my account, that I will be financially responsible for payment of all charges incurred for services received from the Eye Gallery.

Patient Signature _____ Date _____

Retinal Photographic Screening Photos

In our continued effort to bring the most advanced technology available to our patients, Dr. Swikard is proud to offer Digital Retinal Photography as an integral part of your eye exam health. Retinal photography exams provide:

- An eye wellness scan
- An annual, permanent record for your medical file which gives Dr. Swikard comparisons for tracking and diagnosing potential eye disease
- The ability for you to review your retinal image with Dr. Swikard during your exam

Photo documentation is fast and easy. Nothing will touch your eye and usually eliminates the discomfort associated with pupil dilation. It is important to note that should abnormalities be detected or if we cannot obtain an acceptable picture, dilation may be necessary,

Dr. Swikard highly recommends the retinal imaging exam annually for ALL patients. Because your insurance only covers a basic eye exam, advanced screening tools such as Retinal Photography are not typically covered. This enhancement to your general eye exam is discounted from \$95.00 to \$35.00 for patients with insurance. This screening is included for patients who are not using insurance.

PLEASE CHECK ONE ANSWER BELOW AND SIGN

- I ACCEPT
 I DECLINE

Patient Signature _____ Date _____

Contact Lens Examination

If you are currently wearing contact lenses or are interested in being fit with contact lenses, please read and sign the following:

California State laws requires that contact lens wearers have an annual contact lens examination in order to renew their contact lens prescription or buy new lenses. The contact lens exam is not part of the comprehensive eye health of refractive vision test examination. Contact lens patients require additional testing time, measuring and monitoring to evaluate the design and fit of their current lenses, the health of the eye as it relates to contacts or in the case of new wearers, their sustainability to wear contacts.

The contact lens examination fee varies with the complexity of the lens design and diagnostic fitting time and **includes three months of follow-up visits**. Insurance or vision lens benefits may contribute to an allowance. Ask for more details.

PLEASE CHECK ONE ANSWER BELOW AND SIGN

- I ACCEPT
- I DECLINE

Patient Signature _____ Date _____