MONTEREY BAY
EYE CENTER

MEDICAL HISTORY QUESTIONNAIRE

21 Upper Ragsdale Drive, Suite 200
Monterey, CA 93940
P: #831.372.1500 • F: #831.655.6493
montereybayeyecenter.com

Name _____ Date _____

Date of Birth _____ Date of **last eye exam** _____

List all medications you currently take (Rx and over-the-counter). _____

_____

Do you have allergies to any medications? **YES** **NO**

If **YES**, list the medications. _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.).

_____

List any surgeries you have had (cataract, appendectomy, etc.).

_____

Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (Pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, Lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**

Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?..... **YES** **NO**

Have you ever had a blood transfusion?..... **YES** **NO**

Do you drink alcohol?..... **YES** **NO** If YES, how much?_____

Do you smoke?..... **YES** **NO** If YES, how much?_____ How many years?_____

_____ _____

Physician's Signature Date

Monterey Bay Eye Center

Patient Registration

Name: _____ **Soc.Sec. #:** _____

Last First Middle

Sex: ☐ M ☐ F **Age:** _____ **Date of Birth:** _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ **Mobile(Cell) Phone:** _____

Preferred Method of contact (circle one): Home / Mobile (Cell)

May we send appointment reminders to your mobile device? (circle one) YES / NO

Email address: _____

Marital Status: ☐ Single ☐ Married

Preferred Language: _____

Race (optional, please check one):

☐ African-American/Black ☐American-Indian or Alaskan Native ☐Asian ☐Caucasian/White

☐Hispanic ☐Native Hawaiian or Other Pacific Islander ☐Other:_____ ☐Declined to Provide

Ethnicity (please specify or decline) : _____ ☐Declined to Provide

Patient Employed by: _____ **Business Phone:** _____

Primary Care Doctor: _____ **Referring Doctor:** _____

In case of emergency who should be notified?

Name: _____ **Phone:** _____ **Relation:**_____

How did you hear about us? ☐**Word of Mouth** ☐ **Insurance** ☐**DMV** ☐ **Other:** _____

INTERNET: ☐ Our Website ☐ Facebook ☐Google ☐VSP Website ☐AAO

NEWSPAPER/PRINTED: ☐The Carmel PineCone ☐ Herald (Directory/HealthMatters) ☐ Yellow Pages

REFFERRAL: ☐ Referring Physician ☐ Established Patient: _____

MONTEREY BAY
EYE CENTER

REFRACTION POLICY

One of the most important parts of your eye exam is the refraction service. This is the test that we perform with you looking at an eye chart through multiple sets of lenses, until we find the glasses or contact prescription that allows you to see optimally. Refraction also provides us with important information about the function of your eyes and may alert us to any problems that are related to a decrease in visual acuity.

Unfortunately, medical insurances do **NOT** cover this service as they have determined that it is not "medically" necessary. However, if you have vision insurance that covers this service (such as Tricare Prime or Vision Service Plan-VSP), the refraction **IS** a covered service. Please check with your insurance carrier for eligibility and benefits information (Copays may apply).

Our fee for refraction is **$60.00**, and unless you have vision insurance that covers the refraction charge, this fee is **due at the time of service** in addition to any co-payment your plan requires.

Please select and sign below:

□ **Yes, I consent to receive the refraction service.** I accept full financial responsibility for the cost if I do not have vision insurance that covers this.

□ **No, I decline to receive the refraction service.** I understand that the doctor may not be able to fully access the health and function of my eyes.

Print Name: _____

Signature: _____

Date: _____

MONTEREY BAY
EYE CENTER

CONTACT LENS FITTING AND EVALUATION POLICY

21 Upper Ragsdale Drive, Suite 200
Monterey, CA 93940
P: #831.372.1500 • F: #831.655.6493
montereybayeyecenter.com

Contact lenses are considered medical devices, and as such require measurements and evaluation for appropriate fitting, and training by an eye care professional. For current contact lens wearers, it is important that your contact lenses are evaluated annually to ensure that your vision and eye health with the contact lenses are optimized in order to renew your contact lens prescription. Contact lens evaluation for proper fitting requires additional time and measurements. A fee for this service, which is not part of your medical eye exam, will be applied based on the complexity of your prescription.

☐ I would like contact services, and I have read and understand the above Contact Lens Fitting and Evaluation Policy.

☐ I decline contact lens services.

Patient/Guardian's Signature

Date

MONTEREY BAY
EYE CENTER

No-Show/Cancellation Policy
Quality Care for our patients is our priority. Please take a few minutes to review our no-show policy and sign the bottom of the form. If you have any questions please let us know.

Definition of a "No-Show" Appointment

Monterey Bay Eye Center defines a "No-Show" appointment in which the patient either:

- Does not arrive to the appointment
- Cancels with less than 24 hours (1 business day) notice
- Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-Show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

⇒ Potentially jeopardizes the health of the "no showing" patient
⇒ Is unfair (and frustrating) to other patients that would have taken the appointment slot
⇒ Disrespects not only the provider's time, but also the time of the entire clinic staff

How to Avoid Getting a "No-Show"

1. **Confirm** your appointment
2. **Arrive** 10-15 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

Monterey Bay Eye Center will attempt to contact you two business days before your scheduled appointment to confirm your visit. If we are unable to speak with you and have to leave a message, you will have to call Monterey Bay Eye Center to change/cancel your appointment if necessary. your appointment Office Phone Number: 831-372-1500.

2. Always Arrive 10-15 Minutes Early

When you schedule an office visit with us, we expect you to arrive 10-15 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit. Please allow time for parking, at times our lot can be congested enough to make you late to your appointment.

3. Give 24 Hours' Notice if you Need to Cancel

When you need to reschedule/cancel your appointment, we expect you to contact our office no later than 24 hours before your scheduled visit. This allows reasonable time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook a now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us a courtesy call.

Consequences of "No-Show" Appointments

1. **Patient will be charged a $45.00 for every "No Show "**
2. If you miss 3 or more appointments within 1 year you may be dismissed from our practice. Patient dismissal is at the discretion of your provider.

I have read and understand Monterey Bay Eye Center's No-Show/Cancellation Policy and understand my responsibility to plan appointments accordingly and notify Monterey Bay Eye Center appropriately if I have difficulty keeping my scheduled appointment.

_____ _____
PATIENT NAME (PRINT) DATE

_____
PATIENT SIGNATURE OR PARENT/GUAURDIAN IF MINOR

MONTEREY BAY
EYE CENTER

Leland H. Rosenblum, M.D.
Anna J. Shi, M.D.
Roger C. Husted, M.D.
Kasey N. Nakajima, O.D.

Patient Name:

Optional Screening PHOTOS Of The Inside Of Your Eyes

An exam of the retina (the inner lining of your eyes) can lead to early detection of common eye diseases, as well as **signs of other diseases including hypertension, diabetes, and even brain tumors.** Unfortunately, patients may experience some discomfort during the exam which involves dilated pupils and a bright exam-light.

Optional screening photos offer several advantages:

1. Painlessly captures retinal images in just a few seconds.
2. Reduced amount of time and light that the doctor needs for examination because the Screening photo directs the doctor where to concentrate.
3. Usually start with weaker dilating drops; sometimes stronger drops may be required.
4. The **camera** produces stable **wide field** high resolution **photos** which your doctor Required.
5. The images become part of your medical record, enabling your doctor to make important comparisons if problems show up in the future.

Because this is considered a screening examination,

It is **NOT COVERED by health insurance.**

If it is within your budget, we recommend these photos to enhance the effectiveness and comfort of your eye exam.

☐ I choose screening digital retina photos **COST $75.00**

☐ I choose traditional dilated retinal exam (usually covered by medical insurance, except for usual deductibles and co-pays)

Patient Initials: _____ Date: _____