Dr. Julie Ngo, O.D.   Dr. Christopher Campaña, O.D.

WELCOME TO OUR PRACTICE

Today's Date ____________________

Last ____________ First ____________ MI______

Address ____________________

City______________ State _______ Zip Code __________

Date of Birth ____________ Age ________ Sex M F

Home Phone ____________ Cell Phone ____________

Email Address ____________________

Marital Status ____________ Primary Language____________

Race ____________________

Employer (or School) ____________________

Occupation (or Grade) ____________________

Spouse (or Parent's Name) ____________________

Spouse (or Parent's Work) ____________________

Who may we thank for referring you to our office?

____

What is the major purpose of this visit?

____

Any problems with your current contact lenses or eyeglass prescription?

____

Insurance Information

Vision Insurance ____________________

Subscriber Name ____________________

Subscriber SSN ____________________

Subscriber Birth Date ____________________

Primary Medical Insurance ____________________

Subscriber Name ____________________

Subscriber ID# / Group# ____________________

Subscriber Birth Date ____________________

Your routine eye exam + FDT Screener I Self pay eye exam:

____

Family Medical/Eye History (check all that apply)

Is there a family history of any of the following? (M,F,B,S)

	Relationship
Cataracts	☐ ____________
Corneal Problems	☐ ____________
Glaucoma	☐ ____________
Lazy Eye	☐ ____________
Macular Degeneration	☐ ____________
Retinal Problems	☐ ____________
Cancer	☐ ____________
Diabetes	☐ ____________
High Blood Pressure	☐ ____________

The information in this confidential case history form is critical to the evaluation of your vision and health.

The Patient Medical History

Name of Family Physician ____________________

City ____________________

Date of Last Physical Check up ____________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)

____

____

____

Allergies to Medications: ☐ Yes ☐ No

____

Have you ever been diagnosed or treated for the following?

☐ Allergies	☐ Diabetes	☐ Thyroid
☐ Asthma	☐ Heart Disease	☐ Other
☐ Arthritis	☐ High Blood Pressure	____________
☐ Cancer	☐ Kidney	____________
☐ Cholesterol	☐ Nerve	☐ ***No health problems***

Are you Pregnant/Nursing ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No ____packs/day

Do you consume alcohol? ☐ Yes ☐ No mild/mod/heavy

Patient Eye History

Date of Last Eye Exam ____________________

By Whom? ____________________

Have you ever tried contact lenses? ☐ Yes ☐ No

If so, What kind? ____________________

Solutions Used ____________________

Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? ____________________

Do you…(Check box if your answer is yes)

☐ …Drive?

☐ …Work on a computer?

☐ …Spend time outdoors? (how much?) __________ hrs/week

Have you ever been diagnosed or treated for the following?

☐ Cataracts	☐ Iritis/Uveitis
☐ Corneal Abrasion	☐ Lazy Eye
☐ Eye Infection	☐ Macular Degeneration
☐ Glaucoma	☐ Eye Surgery (including LASIK)
☐ Eye Injury	☐ Other eye disorders

Are you currently experiecing...

☐ Blurry Vision	☐ Flash Of Light	☐ Sunlight Sensitivity
☐ Burning	☐ Floater/Spots	☐ Crossed Eye/Eye Turn
☐ Tearing	☐ Grittiness	☐ Trouble seeing at night
☐ Headaches	☐ Itchiness	☐ Uncomfortable Glasses
☐ Double Vision	☐ Occasional Dryness	

OVER

PAYMENT POLICY: (CO) PAYMENTS FOR SERVICES AND MATERIALS ARE DUE AND PAYABLE AT TIME OF SERVICE. The filing of a claim for any services &/or materials rendered **DOES NOT GUARANTEE PAYMENT** from your insurance company. You will be financially responsible for unpaid services and materials. We must emphasize that, as your eye-care provider, our relationship is with you, not your insurance company. Unaccompanied minors must make payment arrangements prior to the appointment. (*Please initial*) ________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information to my insurance carrier or to a licensed physician or health-care provider concerning my illness and treatment. I also request payment of my insurance benefits to Ngo & Campana, OD LLC (Dr. Julie Ngo/Dr. Christopher Campana) (*Please initial*) ________

GEO STANDARD OF CARE: Our philosophy is preventative care. FDT visual field screening is important in the routine eye exam because it can help detect early signs of gluacoma, stroke, brain tumors, macular degeneration, diabetes, high blood pressure and other neurological problems. It can also help monitor changes caused by some medication. This is a non-covered fee of $10. If abnormal, then a more detailed visual field may be requested. (*Please initial*) ________

HIPAA ACKNOWLEDGEMENT: Our Privacy Practice is not to release any of your information without your written consent. See Notice of Privacy Practices (NPP) for details.

Signing below means that you have reviewed, understand, & received our Office Policy, NPP, & the charges. A copy of Office Policy and NPP is available upon request. If you have any questions, please ask the staff to clarify any statements, concerns, and charges prior to services being rendered. Thank you!

Patient/Guardian Signature:______________________________ **Date**: ______________

Advance Beneficiary Notice of Non-Coverage (ABN): Medical & Vision insurances do not cover all services.

Services or Tests	Fees	Description of diagnostic test
Golden Eyes Wellness Exam	**+$65** (savings of $54) _____ Yes, I consent (*Please Initial*)	***Doctor Recommended (Every 1 year):*** *iWellness OCT, Corneal Mapping/Dry Eye Screener, and EyeScreen Imaging* *- Proactive approach to prevent eye disease and maintain healthy eyes* *- Provides baseline data of your eye health. Through time-series-analysis, subtle changes can be examined overtime* *- Catching eye diseases early is the best management for maintaining healthy eyes* *- Dilation is included, if necessary*
Routine pupil dilation	_____ Yes, I consent (*Please Initial*)	*Eye drops that dilate the pupil. Side effects include blurred vision & light sensitivity for 3-6 hours with tropicamide. Routine pupil dilation does not cover cyclopentolate drops (Complex refraction is an additional $45 fee). Side effects may last up to 48 hours.* *- Helps check for retinal holes/tears/abnormalities* *- Paralyzes your ability to focus to obtain a more accurate prescription in patients with accommodative issues* *- Covered by vision plans (routine only, not problem-specific). Must be done the same day as exam*
Description of tests below: You can also choose to select individual testing (Declining Golden Eyes Wellness Exam)		
iWellness OCT	**+ $45** _____ Yes, I consent (*Please Initial*)	*Digital light scan that allows us to see beneath the surface of your retina* *- Best way to discover eye problems at its earliest form* *- Useful to see if stress is affecting your eyes* *- Helpful in determining if certain medications such as Plaquenil, Tamoxifen, or Viagra are damaging your eyes*
EyeScreen Imaging	**+ $39** _____ Yes, I consent (*Please Initial*)	*Digital imaging of your retina, macula, blood vessels, and optic nerve* *- Provides a baseline image of your eye health to assess for eye problems in the future* *- Helpful in diagnosing/managing eye diseases such as Glaucoma and Macular Degeneration* *- Helpful in diagnosing/managing systemic conditions such as Diabetes, Hypertension, and/or High Cholesterol*
Corneal Mapping & Dry Eye Screener	**+ $35** _____ Yes, I consent (*Please Initial*)	*Digital mapping of the surface of your cornea* *- Helpful to diagnose pathological corneal diseases such as Keratoconus* *- Useful for contact lens examination, especially for patients with astigmatism* *- Screener for ocular surface diseases such as Dry Eye*
In refusing to have my eyes dilated, iWellness OCT, EyeScreen, Corneal Mapping, Dry Eye testing, &/or FDT visual field performed, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by these procedures. ______ No, I decline (*Please Initial*)		
Soft Contact Lens Evaluation	______ + $135 Spherical ______ + $165 Toric/Monovision ______ + $195 Multifocal ______ + $235 XR/MF-Toric/MM ______ + $310 New MM ______ + $50 CL training (*Please Initial*) __________	*Contact lenses are medical devices, regulated by the FDA. This means the doctor has to evaluate and re-evaluate the fit of contact lenses on your eyes every year in order to determine the correct prescription. All eyes are different and require different management. Contact lenses are brand-specific. The evaluation depends on the complexity of your prescription. Please review contact lens policy in the Office Policy* *- Evaluation covers up to 3 Follow-up visits within 2 months from the date of your initial exam* *- Requires/includes corneal mapping and dry eye screener ($35 required fee + copay)* *- Includes 1 trial pair of soft contact lenses. Special trial orders can take up to 45 days (depending on the manufacturer)* *- New contact lens wearers must receive contact lens training. It includes wearing instructions and counseling on health related issues for contact lens wearers* *- Training sessions are up to 60 minutes and can be repeated one additional time at another date that is within 2 months of the initial exam date. If patient fails training after the second attempt and wishes to try again, then the patient would have to pay the training fee at a rate of $60 for each session* *- The doctor selects the contacts that are best for the patient. The patient does not dictate the prescription. Thus, we do not fit by formulation and material* *- Established wear applies to patients that have established contacts care at our office & the complexity has not changed*
FINANCIAL POLICY	We accept Visa, MasterCard, Discover, American Express, Apple Pay, Debit, or cash. **Personal checks are NOT accepted**. **Services &/or materials are to be paid-in-full at time of service to proceed with any order. No refunds on service or materials.**	