WOODBRIDGE
OPTOMETRY

Welcome to our practice. We are excited that you selected us as your eye care provider and appreciate the opportunity to help you with all of your eye care and eyewear needs. For almost 40 years we have served the Irvine community. Our doctors specialize in Primary Care, Pediatrics and Low Vision, dry eye treatment, glaucoma and most eye health issues. As a private practice we are committed to providing a lifetime of care for you and your family.

During your visit, our doctors will perform a comprehensive eye examination. Regular, annual eye exams are important in helping you maintain good vision and can detect a number of serious health conditions such as glaucoma and diabetes. Plus, eye exams for children and young adults can spot problems that can impact learning and development.

We are sure that you will want to get your eye examination started soon after you arrive. So, to help process your paperwork, we ask that you complete the enclosed forms and bring them to your visit. These forms will help us get acquainted with you so we can better assess your eye care and visual needs. The information you provide can also help us make recommendations about different eyewear options to fit your specific needs and lifestyle.

Thank you for choosing Woodbridge Optometry. We are looking forward to meeting you. If you have any questions prior to your visit, please contact us at 949-857-0676.

Sincerely,

The Woodbridge Optometry Team

4505 Barranca Pkwy, Suite C, Irvine, California 92604
Phone: 949-857-0676 Fax: 949-857-2175
www.woodbridgeoptometry.com

WOODBRIDGE OPTOMETRY

Patient History Questionnaire

Eye Examination Date: _____/_____/_____

Full Name: _____ Birth Date: _____/_____/_____

Address: _____ Social Security #: _____

_____ Home Phone: _____

Email Address: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Employer: _____ Driver's License #: _____

Medical Doctor: _____ Last Medical Exam: _____/_____/_____

Medical Insurance: _____

Previous Eye Doctor: _____ Last Eye Exam: _____/_____/_____

Vision Insurance: _____ VSP _____ MES _____ EyeMed _____ Other _____

Responsible Party if different: _____ **Relationship to Patient:** _____

Phone: _____ **Billing Address if different:** _____

Who may we thank for referring you to our office: _____

★ PAYMENT IS DUE WHEN SERVICES ARE RENDERED ★

OCULAR HISTORY

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, what type? ☐ Rigid ☐ Soft ☐ Toric ☐ Multifocal ☐ Monovision

☐ Extended Wear Do you wear them ☐ Full Time ☐ Part Time How frequently do you replace them? _____

Have you had refractive surgery? _____ If yes, Date _____ Type _____

What other services would you like to be evaluated for? ☐ Refractive Surgery ☐ Contact Lenses

☐ Computer Glasses ☐ Reading Glasses ☐ Sunglasses ☐ Driving Glasses

Are you having any visual difficulties? _____ If yes, please explain: _____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

☐ Blurred Vision	☐ Flashes / Floaters in Vision	☐ Redness
☐ Loss of Vision	☐ Halos / Glare / Light Sensiitivity	☐ Excess Tearing / Watering
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain or Soreness
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Mucous Discharge
☐ Double Vision	☐ Burning	☐ Inflammation of the Eyelid
☐ Tired Eyes	☐ Itching	☐ Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment / Disease
☐ Crossed Eyes	☐ Lazy Eye / Amblyopia	☐ Dry Eye
☐ Eye Injury	☐ Macular Degeneration	☐ Other _____

MEDICAL HISTORY

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

_____

_____

_____

Are you allergic to any medications? ☐ No ☐ Yes If yes, which ones: _____

List all major surgeries and/or hospitalizations you have had: _____

_____

REVIEW OF SYSTEMS

Please check the box beside any problem you currently have, or have had, in the following areas:

ALLERGIC / IMMUNOLOGIC ☐ All Normal
- ☐ Allergy / Hay Fever

CARDIOVASCULAR / CARDIAC ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

CONSTITUTIONAL ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

EARS, NOSE, MOUTH, THROAT ☐ All Normal
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth

ENDOCRINE ☐ All Normal
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Chronic Fatigue

GASTROINTESTINAL ☐ All Normal
- ☐ Diarrhea / Constipation
- ☐ IBS / Crohn's Disease
- ☐ Ulcers
- ☐ Reflux

GENITOURINARY ☐ All Normal
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

HEMATOLOGIC / LYMPHATIC ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

INTEGUMENTARY (Skin) ☐ All Normal
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising

MUSCULOSKELETAL ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

NEUROLOGICAL ☐ All Normal
- ☐ Migraines
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

RESPIRATORY ☐ All Normal
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

_____

Are you pregnant and / or nursing? ☐ No ☐ Yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

	RELATION TO YOU		RELATION TO YOU
☐ Glaucoma	_____	☐ Diabetes	_____
☐ Cataract	_____	☐ Cancer	_____
☐ Macular Degeneration	_____	☐ Heart Disease	_____
☐ Retinal Detachment	_____	☐ High Blood Pressure	_____
☐ Blindness	_____	☐ Kidney Disease	_____
☐ Crossed Eyes	_____	☐ Lupus / Arthritis	_____

Signature: _____ Date _____/_____/_____

Dry Eye Questionnaire

Name:_____ Date:___/___/___

How **FREQUENTLY** do you experience the following dry eye symptoms?

Symptoms	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

How **SEVERE** are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – Irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Does your face flush after drinking alcohol or exercising? Yes No (Circle)

Do you have trouble seeing at night while driving? Yes No (Circle)

For office use only
Total score (Frequency + Severity) = _____/28

WOODBRIDGE OPTOMETRY

Computer Vision Questionnaire

Please take a moment to complete this questionnaire.

Once completed, take it to your Woodbridge Optometry doctor. Your doctor will then be more familiar with your work environment and better able to determine if you are at risk of developing Computer Vision Syndrome, or if you'll need special computer glasses.

General Information

1. **Indicate time spent:**
   On a computer at work: _____ **hours per day**
   On a computer at home: _____ **hours per day**
   On a handheld computer (e.g., Blackberry):
   _____ **hours per day**

2. **Desktop or laptop computer use:** *(circle applicable)*
   My work computer is a: desktop laptop
   My home computer is a: desktop laptop

3. **Lighting in work area:** *(please describe)*
   Overhead / desk:
   _____
   Incandescent / fluorescent:
   _____

4. **Are you experiencing any of the following symptoms while at your computer monitor?**
   Check where appropriate
   - ❍ Headaches
   - ❍ Sore or tired eyes *(eye strain)*
   - ❍ Blurred near vision
   - ❍ Glare (light) sensitivity
   - ❍ Blurred distance vision
   - ❍ Dry or watery eyes
   - ❍ Burning, itching or red eyes
   - ❍ Back pain
   - ❍ Neck and shoulder pain
   - ❍ Double vision

5. **Do you wear glasses while working at the computer?**
   ❍ Yes ❍ No
   (If yes, please bring them with you to your eye exam.)

6. **Do you wear comtact lenses while working at the computer?**
   ❍ Yes ❍ No
   (If yes, please wear them for your eye exam.)

7. **Do you view reference material while working at the computer?**
   ❍ Yes ❍ No
   (If yes, what percentage of time? _____***)***

In order for your Woodbridge Optometry doctor to accurately assess your computer vision needs and possible appropriate eyewear, the following must also be completed.

Distances / Direction

8. **Viewing distance (eye to computer screen) is** _____ inches.

9. **Viewing distance (eye to keyboard) is** _____ inches.

10. **Viewing distance (eye to reference material) is** _____ inches.

11. **The center of the computer screen is:** *(circle one)*

above eye level	equal to eye level	below eye level

If above or below, by how many inches? _____

12. **Reference material is:** *(circle one)*

above eye level	equal to eye level	below eye level

If above or below, by how many inches? _____

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WOODBRIDGE
OPTOMETRY

Financial Policy

In our continued commitment to provide the highest quality vision care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment. ***Please check your preferred method of payment:***

❍ **Cash** ❍ **Personal Check** ❍ **Visa** ❍ **Discover** ❍ **MasterCard** ❍ **American Express**

We are pleased to offer the following financing option which is administered for us by

❍ **CARE CREDIT**

Please ask our administrative staff for details and credit applications.

We are committed to support you in understanding your eye health, so that you will always be able to make the best choices.

We will, as a courtesy, process your insurance benefits (which we are panel members), which will relieve you of this time consuming and sometimes complicated task.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any service / treatment that is not a benefit of any vision insurance that I may have. I understand that all non-insurance services and products are due to be paid in full at the date of service. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts that are unpaid 30 days from service date.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. If, for any reason, you should need to change your appointment, there will be no charge, provided you give us **24-hour notice to avoid a $40 cancellation fee.** Please help us serve you better by keeping your scheduled appointments.

REFUNDS ❍ All material refunds for Glasses and/or Contact Lenses will be issued as Woodbridge Optometry credit only. Professional Services rendered will not be refunded.

We are here to assist you in any way possible. Please make your questions and concerns known to our team ... *Our goal is to ensure that you have an outstanding experience*

Signature (Responsible Party) Date Financial Coordinator

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HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provide information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:_____
Printed Name-Patient or Responsible Party

_____
Patient Signature or Responsible Party Date

_____
Relationship to patient (if other than patient)

Witness: _____
Printed Name-Practice Representative

_____ ____/_____/____
Signature Date