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Doctors of Optometry

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## Welcome to Our Office

Name \_\_\_\_\_  
Street \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Daytime phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Email address \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Hobbies/Sports \_\_\_\_\_  
Special Needs \_\_\_\_\_  
Spouse (or parent) name \_\_\_\_\_  
Spouse (or parent) daytime phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Vision Insurance \_\_\_\_\_  HMO  PPO  
 POS  
Medical Insurance \_\_\_\_\_  HMO  PPO  
 POS  
Patient's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Insured's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Method of payment today?

- Check  Cash  Visa or MC or Discover or AMEX  
 Insurance, please specify type \_\_\_\_\_  
 School District contract. Which one? \_\_\_\_\_

### How Did You Hear About Our Office?

Friend or Relative. Who? \_\_\_\_\_  
Another health care practitioner. Who? \_\_\_\_\_  
School District. Which one? \_\_\_\_\_  
Yellow pages. Which directory? \_\_\_\_\_  
Internet.  
Previous patient. Who? \_\_\_\_\_  
Participating eye care plan. Which one? \_\_\_\_\_  
Walk in.  
Other. \_\_\_\_\_

Today's date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex: Male Female  
Last comprehensive vision and eye health exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Name of Eye Doctor \_\_\_\_\_ City \_\_\_\_\_  
Last complete physical \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Primary Care physician \_\_\_\_\_ City \_\_\_\_\_

### Office Policies

Professional fees are due at the time services are rendered. Full payment is required when an order for glasses or contacts is placed. Professional fees are non-refundable. We accept Visa, MasterCard, Discover, American Express, and checks with valid identification. We also accept assignment on many types of vision insurance. There is a 25% service charge on all cancelled orders once the job has been started.

### Contact Lens Policies

Contact lenses are medical devices that require a comprehensive vision and eye health evaluation before they are prescribed.

If contact lenses are appropriate for you, follow-up medical management is required. We will release your prescription to you after the doctor has determined that the contact lenses meet all the criteria for proper eye health and visual acuity specific to your case.

If you are unable to adapt to your contact lenses, you have within 90 days the option to: (1) change to a different type of contact lens and pay the difference should there be any, or (2) apply the amounts paid less the professional fees toward the purchase of glasses. No cash refunds will be given, only office credit with the return of contact lenses in good condition.

Package prices for the various types of contact lenses include a comprehensive vision and eye health evaluation, all follow-up medical management and care, as well as the contact lenses.

### Returned Check Policy

Any check returned to us as insufficient funds shall be charged a \$25 service fee in addition to the value of the check. Additional fees as high as three times the amount of the check as well as collection fees may be charged if prompt payment of the returned check is not made.

I HAVE READ AND UNDERSTOOD THE ABOVE STATED POLICIES.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Insurance Authorization

I certify that the information given by me in applying for insurance and/or Medicare payments is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. Susan Daniel on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature below authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OVER, please →**

**Diagnostic Issues**

Please tell us why you are here today...

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- Do you currently wear glasses? No Yes
- Do you have more than 1 pair of current Rx glasses? No Yes
- Do you work on a computer? No Yes
- Do you sometimes experience dry eyes? No Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? No Yes
- Do you spend a lot of time outdoors? No Yes
- If you wear bifocals, are you bothered by restricted windows, lines, or head tilting? No Yes
- Are there times you'd rather not wear glasses? No Yes
- Do you wear contact lenses? No Yes  
 Type: \_\_\_\_\_ Brand: \_\_\_\_\_  
 Wearing schedule: \_\_\_\_\_  
 Solutions: \_\_\_\_\_
- If you wear contact lenses, are you satisfied with vision and comfort? No Yes
- Are you interested in a "test drive" of the latest in contact lens design(s)? No Yes
- Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy? No Yes

**Do You Experience...**

- Any discomfort with your eyes? No Yes
- Problems with glare or reflection? No Yes
- Sensitivity to sunlight? No Yes
- Loss of vision? No Yes
- Blurred vision? No Yes
- Distorted vision / Halos? No Yes
- Loss of side vision? No Yes
- Double vision? No Yes
- Dryness? No Yes
- Redness? No Yes
- Sandy or gritty feeling? No Yes
- Itching? No Yes
- Burning? No Yes
- Sties or Chalazions? No Yes
- Tired Eyes? No Yes
- Floater, spots, or flashes of light? No Yes

**Personal & Family Medical History**

- High / Low Blood Pressure No Self Family Who? \_\_\_\_\_
- Diabetes No Self Family Who? \_\_\_\_\_
- Thyroid Conditions No Self Family Who? \_\_\_\_\_
- Heart / Vascular Disorders No Self Family Who? \_\_\_\_\_
- Asthma / Bronchitis / Lung Disorders No Self Family Who? \_\_\_\_\_
- Cancers / Tumors No Self Family Who? \_\_\_\_\_
- Kidney / Liver Disorders No Self Family Who? \_\_\_\_\_
- Arthritis / Rheumatoid No Self Family Who? \_\_\_\_\_
- Fainting / Dizziness No Self Family Who? \_\_\_\_\_
- Seizures No Self Family Who? \_\_\_\_\_
- Glaucoma No Self Family Who? \_\_\_\_\_
- Retinal Disease No Self Family Who? \_\_\_\_\_
- Blindness No Self Family Who? \_\_\_\_\_
- Cataracts No Self Family Who? \_\_\_\_\_
- Eye Head Injury No Self Family Who? \_\_\_\_\_
- Color Blindness / Deficiency No Self Family Who? \_\_\_\_\_
- Headaches / Migraines No Self Family Who? \_\_\_\_\_
- Eye Turn / Lazy Eye No Self Family Who? \_\_\_\_\_
- Vision Training / Eye Exercises No Self Family Who? \_\_\_\_\_
- Eye Surgery No Self Family Who? \_\_\_\_\_
- Psychiatric Disorder No Self Family Who? \_\_\_\_\_
- Women only:  
Are you pregnant? No Yes
- Women only:  
Are you nursing? No Yes
- Other History? \_\_\_\_\_

**Current Medications**

*Rx, over-the-counter, herbs, vitamins, supplements, etc.*

Name of Medication      Dosage      What is it for?

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Are you currently under the care of a physician?      No      Yes

Name of physician \_\_\_\_\_

Allergies including medications? (please list)

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THANK YOU