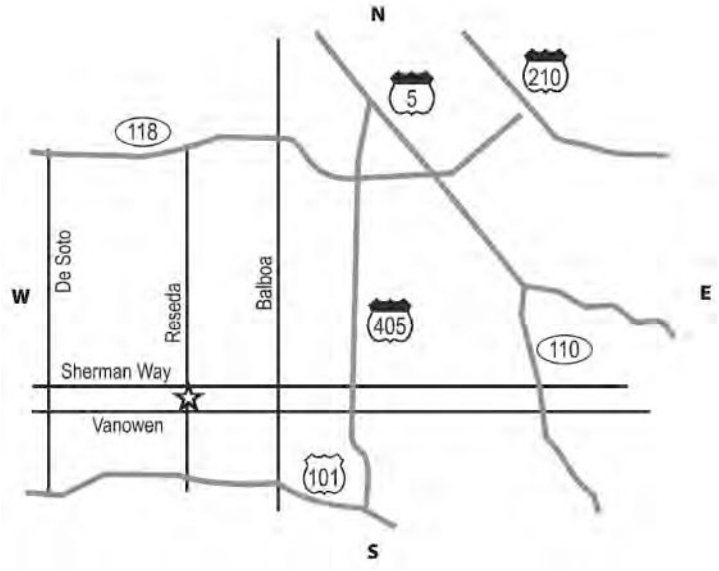
ZDENEK EYE INSTITUTE
Gene W. Zdenek, MD
Refractive Eye Physician and Surgeon
American Board of Ophthalmology

Welcome to Zdenek Eye Institute and thank you for scheduling your appointment with Dr. Zdenek. We are located on Reseda between Sherman Way & Hart St. We do have free parking in the back of our building off Canby St.



If you would like to save some time at check in, please print ALL these forms and complete them to the best of your ability. Bring them with you to your scheduled appointment along with your medical insurance card, driver's license and a list of any prescription you may be taking. You can also complete them in Adobe, save them and email the completed forms to scheduling@FyEye.com.

See you soon,

Dr. Zdenek and Staff

7012 Reseda Boulevard, Suite B-105, Reseda, California, 91335
Office: (818) 708-2222 | Fax: (818) 342-3937 | Email: DocZ@FyEye.com | FyEye.com

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Patient Information

Today's Date: _____

Patient Name: _____ Preferred Name: _____ Sex: ☐ M ☐ F
(*First*) (*Last*)

Address: _____ City: _____ St: CA Zip: _____

SSN: _____ DL#: _____ DL ST: CA Date of Birth: _____ Age: _____

Marital Status: Never Married Home/Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Employer Information

Employer: _____ Business Phone: _____

Responsible Party Information

Responsible Party: _____ ☐ Self DL#: _____ St: CA
(*First*) (*Last*)

Address: _____ City: _____ St: CA Zip: _____

SSN: _____ Home/Cell Phone: _____ Work Phone: _____

Email Address: _____

Insurance Information

Select all that apply

☐ Private ☐ Medicare ☐ Medi-Cal ☐ Vision Ins ☐ HMO ☐ None

Primary Insurance

Insurance Co Name:_____

ID#: _____

Secondary Insurance

Insurance Co Name:_____

ID#: _____

By signing below, I acknowledge Zdenek Eye Institute's Privacy Practice Policy, which follows HIPPA guidelines. (To request a copy of the HIPPA Information document, please inform our office staff.) I understand that I am financially responsible for all charges, whether or not paid by my insurance carrier. Payments may be due at the time services are rendered. I assume responsibility for all fees not paid to this office by my insurance carrier. A finance charge of $25 may be applied to any balance over 90 days past due.

I have read and understand the above statements.

Parent/Guardian Signature: _____ Date: _____

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Zdenek Eye Institute

Patient Health History

Welcome to our Practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name: _____ Age: _____ Date: _____

☐ Male ☐ Female Primary Care Physician: _____ City: _____

Eye History

Have you ever had the following eye conditions? (Check "no" or "yes", leave blank if uncertain) **Explanation**

Glaucoma, Cataracts, Etc.	☐ No	☐ Yes	
Loss of Vision	☐ No	☐ Yes	
Blurred Vision	☐ No	☐ Yes	
Fluctuating Vision	☐ No	☐ Yes	
Distorted Vision	☐ No	☐ Yes	
Loss of Side Vision	☐ No	☐ Yes	
Double Vision	☐ No	☐ Yes	
Dryness	☐ No	☐ Yes	
Mucous Discharge	☐ No	☐ Yes	
Redness	☐ No	☐ Yes	
Lazy Eye/Crossed Eye	☐ No	☐ Yes	
Sandy or Gritty	☐ No	☐ Yes	
Itching	☐ No	☐ Yes	
Burning	☐ No	☐ Yes	
Foreign Body Sensation	☐ No	☐ Yes	
Excess Tearing	☐ No	☐ Yes	
Glare/Light Sensitivity	☐ No	☐ Yes	
Pain or Soreness	☐ No	☐ Yes	
Infection	☐ No	☐ Yes	
Tired Eyes	☐ No	☐ Yes	
Drooping Eyelid	☐ No	☐ Yes	
Other	☐ No	☐ Yes	

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

Medications: (Include Non-Prescription) _____

_____

Have you ever taken Fen-Phen/Redux? ☐ Yes ☐ No Have you ever taken Flomax? ☐ Yes ☐ No

Patient Social History: (Check Appropriate Answer)

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily, If daily, how much per day? _____

Use of Tobacco: ☐ Never ☐ Previously, but not in the past _____ years(s) ☐ Yes, If yes: Current packs/day:_____

Do you have visual difficulty when driving? ☐ Yes ☐ No

Do you currently wear: ☐ Contact Lenses ☐ Glasses ☐ Neither

Have you considered: ☐ LASIK ☐ Contact Lenses ☐ Cosmetic Eyelid Surgery ☐ SSP (Presbyopia Surgery)

Other consideration (not listed above)? _____

Do you have any of the following hobbies or interests?

☐ Water Sports	☐ Jogging/Running	☐ Bicycling	☐ Reading
☐ Watching TV / Movies	☐ Tennis	☐ Golf	☐ Computer
☐ Driving	☐ Walking	☐ Aerobics	☐ Gym Workout
☐ Scrapbooking	☐ Sewing	☐ Needlework	☐ Knitting / Crochet

Others (not listed): _____

_____

Family Medical History:

	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good general health lately	❑ No	❑ Yes
Recent weight change	❑ No	❑ Yes
Fever	❑ No	❑ Yes
Fatigue	❑ No	❑ Yes

Ears/Nose/Mouth/Throat

Earaches or drainage	❑ No	❑ Yes
Chronic sinus prob. or rhinitis	❑ No	❑ Yes
Fever	❑ No	❑ Yes
Fatigue	❑ No	❑ Yes

Neurological

Numbness or tingling sensation	❑ No	❑ Yes
Paralysis	❑ No	❑ Yes
Headaches	❑ No	❑ Yes
Light headed or dizzy	❑ No	❑ Yes
Convulsions or seizures	❑ No	❑ Yes
Tremors	❑ No	❑ Yes
Head injury	❑ No	❑ Yes

Hematologic/Lymphatic

Anemia	❑ No	❑ Yes
Bleeding or bruising tendency	❑ No	❑ Yes
Slow to heal after cut	❑ No	❑ Yes
Phlebitis	❑ No	❑ Yes
Past transfusion	❑ No	❑ Yes
Enlarged glands	❑ No	❑ Yes

Diabetes	❑ No	❑ Yes
High Blood Pressure	❑ No	❑ Yes

Respiratory

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	❑ No	❑ Yes
Shortness of breath	❑ No	❑ Yes
Wheezing	❑ No	❑ Yes
Spitting up blood	❑ No	❑ Yes
Tuberculosis	❑ No	❑ Yes

Gastrointestinal

Loss of appetite	❑ No	❑ Yes
Change in bowel movements	❑ No	❑ Yes
Frequent diarrhea	❑ No	❑ Yes
Nausea or vomiting	❑ No	❑ Yes
Painful bowel movements or constipation	❑ No	❑ Yes
Rectal bleeding or blood in stool	❑ No	❑ Yes
Abdominal pain	❑ No	❑ Yes

Psychiatric

Memory loss or confusion	❑ No	❑ Yes
Depression	❑ No	❑ Yes
Nervousness	❑ No	❑ Yes
Insomnia	❑ No	❑ Yes

Cardiovascular

Heart trouble	❑ No	❑ Yes
Chest pain or angina pectoris	❑ No	❑ Yes
Palpitation	❑ No	❑ Yes
Shortness of breath when walking or lying down	❑ No	❑ Yes
Swelling of feet, ankles or hands	❑ No	❑ Yes

Musculoskeletal

Joint pain	❑ No	❑ Yes
Joint stiffness or swelling	❑ No	❑ Yes
Muscle pain or cramps	❑ No	❑ Yes
Weakness pain or cramps	❑ No	❑ Yes
Back pain	❑ No	❑ Yes
Cold extremities	❑ No	❑ Yes
Difficulty in walking	❑ No	❑ Yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	❑ No	❑ Yes
Morphine, Demerol, or other narcotics	❑ No	❑ Yes
Novocain or other anesthetics	❑ No	❑ Yes
Aspirin or other pain remedies	❑ No	❑ Yes
Tetanus antitoxin or other serums	❑ No	❑ Yes
Latex	❑ No	❑ Yes

Other drugs/medications: _____

_____

_____

_____

Known food allergies: _____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient or Guardian if Minor | Date

Doctor's Review

_____ _____

Signature of Doctor | Date

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Refraction & Contact Lens Waiver

Name: _____ **Date**: _____

Insurance: _____ Medical Insurance _____ Vision Insurance Refraction Coverage: ❑ Yes ❑ No

Eye Care for Heroes: Active or Retired Military Service ❑ Yes ❑ No

Refraction Exam for Glasses:

If you are not able to see 20/20 when Dr. Zdenek tests your vision then a refraction test is necessary. If you cannot see 20/20 then this test will help rule out medical conditions and/or determine the most accurate eyeglass prescription. This is different than a contact lens prescription; a different test/exam is needed for contact lenses.

Private medical insurance and Medicare DO NOT cover the cost of this test.
These insurances ONLY cover the examination procedures needed to determine the eye's health for the prevention and diagnosis of diseases.
Vision insurance WILL cover the cost of this test.

Contact Lens Exam:

Current Contact Lens Information

_____ Brand (ex. Acuvue Oasys, Air Optix) _____ Size (ex. 8.4)

Power: Right Eye _____ Left Eye

To check the health of your cornea, measurements to determine shape of the eye, test to determine lens power and correct fit of contact lenses

A contact lens fit is required in order to receive a Prescription for Contact Lenses. This will allow us to determine the best contact lens for you. Medical insurance DOES NOT cover the cost of a contact lens fit.

If you have had a Refraction or Contact Lens Exam with Dr. Zdenek within the last 2 years, then you will receive a **$20 - $100 discount** on your Exam today. Ask one of our staff members if you qualify for a discount.

Please select what type of exam you would like during your visit today.

☐ **Eye glass Exam $75** ☐ **Contact lens Exam $225**

☐ **Contact lens + Eye Glass Exam $250** ***(Save $50)***

☐ **I <u>decline</u> and understand that I cannot be given a prescription**

Your medical insurance will not be billed with the above selection. If you would like a Complete Eye Exam, ask a staff member if your insurance covers a Complete Eye Exam.

I understand that I will be charged the above pricing based on my selection. Payment is due at the time services are rendered.

_____ Signature _____ Date

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Tear Function Survey

Dry, scratchy, irritated eyes? Eye irritation can be subtle or extreme ranging from the occasional dry or gritty sensation to ongoing tearing and discharge. Depending on the severity of your symptoms, you may be suffering from more serious conditions such as Dry Eye Disease and Meibomian Gland Dysfunction, both of which will compromise tear production and functionality.

The only person that can make a Dry Eye Disease diagnosis and provide treatment options is your doctor. To assist Dr. Zdenek in determining what's right for you, please answer the following questions.

_____ _____
Print Patient Name Date

1. Do your eyes feel or have you experienced the following?

	Never	Slight	Moderate	Severe
a.) Gritty or sandy sensation	☐	☐	☐	☐
b.) Tired or soreness	☐	☐	☐	☐
c.) Fluctuating vision	☐	☐	☐	☐
d.) Occasional tearing or watery eyes	☐	☐	☐	☐
e.) Blurred vision while reading	☐	☐	☐	☐
f.) Discomfort in windy conditions	☐	☐	☐	☐
g.) Discomfort in air conditioned areas	☐	☐	☐	☐

2. Do you EVER suffer from red, itchy, burning eyes or swollen eyelids? ☐ Yes ☐ No

3. Do you EVER use over-the-counter eye drops (i.e. Visine A, Visine A.C., Opcon-A, etc) to relieve red, itchy, watery eyes or swollen eyelids? ☐ Yes ☐ No

4. Do you take oral medications/antihistamines such as Claritin, Allegra or Zyrtec for your allergies? ☐ Yes ☐ No

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Policy on Patient Responsibility for Fees

Thank you for coming to Zdenek Eye Institute. We believe that good care for you and your family starts with good communication, and we have created this policy to help our patients understand the responsibilities that they and their families have for payment of our fees. If at any time you have questions or concerns with our fees or payment process, please don't hesitate to speak with *David at (818) 708-2222 or dv@fyeye.com.*

We require that our patients promptly pay all charges that we present to them. If we present a charge to you, it means that we have taken any insurance adjustment and/or discounts into account and that you must pay the amount remaining. If you are reimbursed directly by a program for the cost of your care, you must still pay our charges promptly, whether or not you have received that reimbursement. Additionally, to make it easier for our patients to pay future balances we require a credit card on file, stored securely. If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them.

Payment for our services is due at the time that those services are provided to you. This includes, among other things, copay amounts, program deductibles, earlier charges that remain unpaid, and charges for services that we believe are not covered by, or are left over as your responsibility to pay after coverage by, insurance or government programs. We or our agents may send you statements and reminders and calls of charges made and amounts that must be paid. By accepting our services, you are consenting to receive these communications.

Discounts may be available for prompt/early payments. Past Due balances may be subject to penalties and interest. If no payments on past due balances are made in 90 days we may place your account with our collections agency. In some instances monthly payment plans may be made with our office manager, please ask for details.

I understand the above information, and I will be financially responsible for the following patient:

_____

Print Patient Name

_____ _____

Signature: also print name, if different from patient Date