

# ZDENEK EYE INSTITUTE

**Gene W. Zdenek, MD**

Refractive Eye Physician and Surgeon  
American Board of Ophthalmology

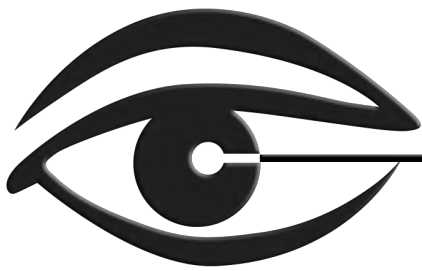
Welcome to Zdenek Eye Institute and thank you for scheduling your appointment with Dr. Zdenek. We are located on Reseda between Sherman Way & Hart St. We do have free parking in the back of our building off Canby St.



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](mailto:scheduling@FyEye.com).

See you soon,

Dr. Zdenek and Staff



# ZDENEK EYE INSTITUTE

## Gene W. Zdenek, MD

Refractive Eye Physician and Surgeon  
American Board of Ophthalmology

### Patient Information

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Sex: M F  
 (First) (Last)

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ DL#: \_\_\_\_\_ DL ST: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Employer Information

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

### Responsible Party Information

Responsible Party: \_\_\_\_\_ Self DL#: \_\_\_\_\_ St: \_\_\_\_\_  
 (First) (Last)

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Insurance Information

Private     Medicare     Medi-Cal     Vision Ins     HMO     None

*Select all that apply*

**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: \_\_\_\_\_

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.....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Loss of Vision .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Blurred Vision .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Fluctuating Vision .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Distorted Vision .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Loss of Side Vision .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Double Vision .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Dryness .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Mucous Discharge .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Redness .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Lazy Eye/Crossed Eye .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Sandy or Gritty .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Itching .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Burning .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Foreign Body Sensation .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Excess Tearing .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Glare/Light Sensitivity .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Pain or Soreness .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Infection .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Tired Eyes .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Drooping Eyelid .....	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Other .....	<input type="checkbox"/> No	<input type="checkbox"/> 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?

- |   |  |                                     |   |
|---|--|-------------------------------------|---|
| <input type="checkbox"/> Water Sports         | <input type="checkbox"/> Jogging/Running | <input type="checkbox"/> Bicycling  | <input type="checkbox"/> Reading            |
| <input type="checkbox"/> Watching TV / Movies | <input type="checkbox"/> Tennis          | <input type="checkbox"/> Golf       | <input type="checkbox"/> Computer           |
| <input type="checkbox"/> Driving              | <input type="checkbox"/> Walking         | <input type="checkbox"/> Aerobics   | <input type="checkbox"/> Gym Workout        |
| <input type="checkbox"/> Scrapbooking         | <input type="checkbox"/> Sewing          | <input type="checkbox"/> Needlework | <input type="checkbox"/> Knitting / Crochet |

Others (not listed): \_\_\_\_\_

**Family Medical History:**

	<u>Age</u>	<u>Medical/Eye Diseases</u>	<u>If Deceased, Cause of Death</u>
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.

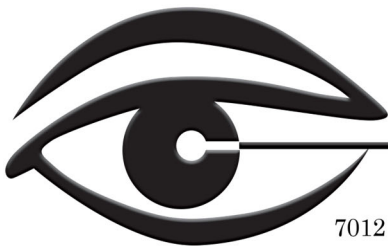
\_\_\_\_\_  
Signature of Patient or Guardian if Minor

\_\_\_\_\_  
Date

**Doctor's Review**

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date



# ZDENEK EYE INSTITUTE

## Gene W. Zdenek, MD

7012 Reseda Blvd. Suite B., Reseda, CA 91335    FyEye.com    O: (818) 708-2222    F: (818) 342-3937

### 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)**

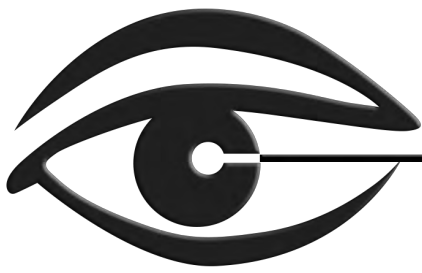
**I decline and understand that I cannot be given a prescription**

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



### *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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.) Tired or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.) Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.) Occasional tearing or watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.) Blurred vision while reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.) Discomfort in windy conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.) Discomfort in air conditioned areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

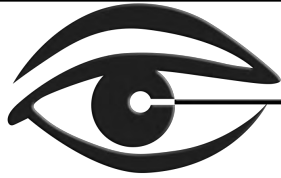
Yes

No

4. Do you take oral medications/antihistamines such as Claritin, Allegra or Zyrtec for your allergies?

Yes

No



ZDENEK EYE INSTITUTE

Gene W. Zdenek, MD

Refractive Eye Physician and Surgeon  
American Board of Ophthalmology

## 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