Kraig J. Abe, O.D., F.A.A.O., F.I.A.O.M.C.

19665 Stevens Creek Boulevard • Cupertino, CA 95014-2422 • Phone: (408) 252-3662

Welcome To Our Office !

PATIENT INFORMATION (Please Print)

Last Name First Name Initial Sex M ☐ F ☐ Date of birth Age

Home Address City / State / Zip Code Home phone ( )

Occupation Employer Email address Work/Cell phone OK to text Y N ( )

Spouse's name Children's name(s) / age Patient Status ☐ Single ☐ Married ☐ Student ☐ Other

Who referred you to our office? ☐ Insurance list ☐ Family member Signature Today's Date

Name: ☐ Yellow pages ☐ Internet

PATIENT HISTORY (Please answer to the best of your knowledge)

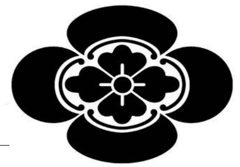
1. How old are your GLASSES: ________ CONTACT LENSES: R________ L _________ previous **eye Dr**:______________________
2. Date of last eye exam:________________ Have your eyes been dilated by your eye doctor? (when ?___________) ☐ No ☐ Yes
3. **What is the *MAIN REASON* for today's visit ?**____
4. Name / location of your **primary physician**:_________________________________ date of last **physical** exam:______________
5. Do you or any blood relatives have (please check box and state **who**)?
   - ☐ retinal disease **who:**__________ ☐ high blood pressure **who:**__________ ☐ tuberculosis **who:**__________
   - ☐ cataracts **who:**__________ ☐ thyroid problems **who:**__________ ☐ hepatitis **who:**__________
   - ☐ glaucoma **who:**__________ ☐ heart condition **who:**__________ ☐ cancer **who:**__________
   - ☐ diabetes **who:**__________ ☐ high cholesterol **who:**__________ ☐ other **who:**__________
6. **Females**: Are you ☐ pregnant ☐ nursing ? ☐ No ☐ Yes
7. Are you being treated for any medical condition or taking medications ? ☐ No ☐ Yes
   Please list condition and medication: ____
8. Do you have any allergies or are you allergic to any medications ? ☐ No ☐ Yes
   Please List:____
9. Do you or have you ever had any eye disease, eye infection, injury, or surgery ? ☐ No ☐ Yes
   If yes, please explain:____
10. Do you smoke ? ☐ Yes ☐ No Alcohol consumption: ☐ none ☐ occasional ☐ often Recreational drug use: ☐ No ☐ Yes
11. Do you experience while wearing your glasses or contact lenses ?
    - ☐ eyestrain ☐ tearing ☐ eye pain ☐ double vision ☐ trouble with night vision ☐ driving at night
    - ☐ dry ☐ burning ☐ itchy eyes ☐ blurred vision ☐ unusual sensitivity to bright lights
    - ☐ spots / floaters ☐ flashes of light ☐ frequent or severe headaches ☐ other__________________
12. Have you ever been prescribed eye exercises ? ☐ No ☐ Yes
13. Special visual demands (work, hobbies, or activities) ________________________________
14. Are you interested in contact lenses ? (choose) : ☐ **new** ☐ **color** ☐ **bifocal** ☐ **nearsightedness reducing** ☐ No ☐ Yes
15. Are you interested in laser vision correction surgery ? ☐ No ☐ Yes

COMPUTER USERS If you work on a computer, please answer the following:

16. Hours per day:_______ Size of computer monitor(s):___________(inches) Distance from computer screen:__________(inches)
17. Are you experiencing: ☐ eyestrain ☐ blurred vision ☐ headaches while using the computer ? ☐ No ☐ Yes

CONTACT LENSES If you wear contact lenses, please answer the following:

18. Days per week worn: ________ Hours per day: ________ Brand / Name of contacts:______________________
19. Type of contacts: ☐ Hard ☐ Oxygen Permeable (RGP) ☐ Soft ☐ Disposable ☐ Astigmatism ☐ Bifocal ☐ Monovision
20. Method of wear: ☐ Daily wear ☐ Flexible wear ☐ Extended wear (overnight) When contacts were last worn:______________
21. Care System: ☐ Heat ☐ Chemical Enzyme use : ☐ Yes ☐ No Name of solution:__________________
22. Are you **SATISFIED** with your current brand / type of contact lenses ? ☐ No ☐ Yes



Name:

Privacy Policy

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail. It may be viewed on the "Our Practice" page.

I acknowledge that I have viewed or have been offered and/or received a copy of the Privacy Policy from Dr. Kraig J. Abe (Dr. Abe).

DATE SIGNATURE

Financial Disclaimers

Eligibility for medical insurance and/or routine vision benefits
We will attempt to verify your plan eligibility for services and/or materials before your appointment. ***Verification of eligibility is done as a courtesy only and is not a guarantee of payment.*** Please check with your plan administrator if you have any questions regarding your eligibility.

INITIALS

Liability
I understand that account balances and co-payments are due at time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Dr. Abe. I also authorize Dr. Abe to release any information required for payment to be made. ***If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full or the remaining balance.*** My signature below verifies that I understand this agreement and the above financial disclaimers.

DATE SIGNATURE OF PATIENT IF OVER 18 OR PARENT OF PATIENT

Baseline Digital Retinal Imaging

Digital retinal imaging is a technology which involves capturing a high-resolution digital image of the interior portion of your eye, the retina. This technology provides us with a digital retinal fingerprint and serves as a baseline for comparison at future visits. It is an excellent tool for preventative care. We image patients if: ***You have a family history of eye disease, including glaucoma, blindness, retinal detachment, macular degeneration, or other eye conditions*** or ***if you are diabetic, hypertensive, have rheumatoid arthritis, or use high-risk medications, including steroids or chloroquine.*** Digital imaging is quick, and the images are available immediately. We can also provide you with a copy of your photos via email so you can keep them with you for your own records.
The fee for retinal digital imaging is $25. Currently this cannot be billed to insurance. Please initial below.

_________ ***YES, I would like my eyes digitally monitored through retinal imaging.***

_________ ***NO, I do not want to have digital retinal imaging.***

Contact Lens Fees

Contact lens evaluation services are not an included part of an eye health evaluation and vision assessment, and additional fees apply. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient.
Fees for contact lens evaluation services range between $75 and $325 (keratoconus and orthokeratology fees higher). As with glasses, contact lens materials are an additional fee. My signature below verifies I understand the contact lens fees.

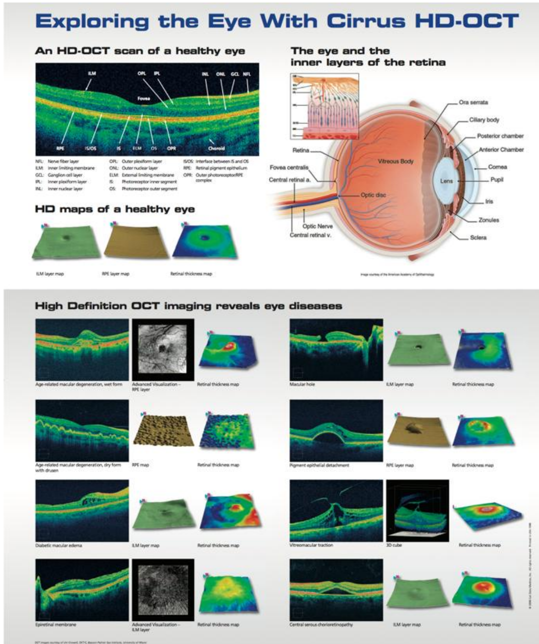
DATE SIGNATURE

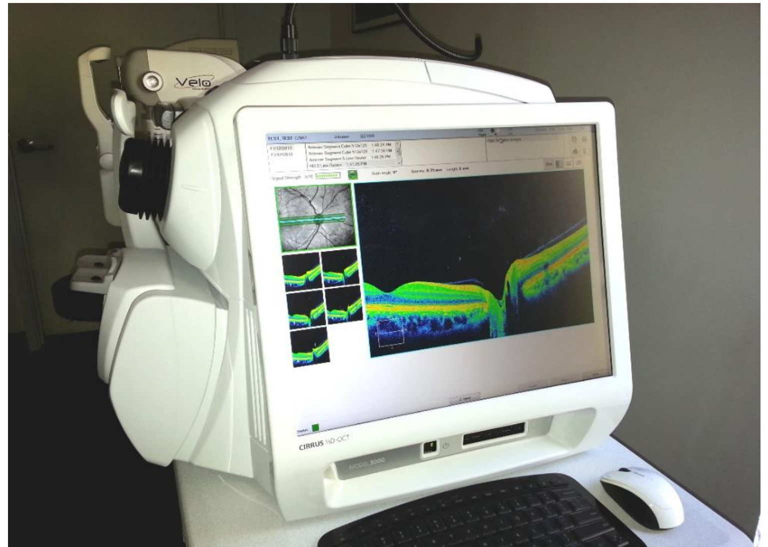
Refraction Fee

The part of your evaluation that determines your prescription is called a refraction. A refraction is also done under certain circumstances for diagnostic purposes. ***If you have routine vision benefits such as VSP, EyeMed or Medical Eye Services, your refraction is typically included with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover a refraction. The fee for a refraction is $60.*** My signature below verifies I understand the refraction fee.

DATE SIGNATURE

ZEISS WELL VISION EXAM





In an effort to provide a more thorough eye examination, Dr. Abe has joined with other leading-edge practices now performing comprehensive exams using the Zeiss Cirrus Ocular Coherence Tomographer (OCT).

Similar to an MRI of the eye, the Zeiss Well Vision Exam (ZWVE) scan reveals ocular anatomy and early signs of disease in exquisite detail. This leading edge technology allows Dr. Abe to examine, with unprecendented clarity, ocular health elements that are invisible using traditional eye exam methods.

The imaging can help detect potentially sight threatening diseases in the very early stages, when they are most treatable. In addition, some systemic diseases may also be detected.

Diseases that the ZWVE scan can help detect includes glaucoma, macular degeneration, diabetic and hypertensive retinal changes, retinal changes due to certain medications, eye tumors, multiple sclerosis, among others.

As part of your pre-exam testing, our technician will perform the Zeiss Well Vision Exam, which Dr. Abe will review with you during your examination today. There is a $39 copay that is not covered by your vision or medical insurance.

Please let us know if you have any questions about the Zeiss Well Vision Scan.

❑ YES. I wish to have the Zeiss Well Vision Exam to rule out sight threatening ocular and systemic diseases.

❑ I am unsure if I should do the Well Vision Exam and would like to discuss the benefits with Dr. Abe during my exam.

❑ NO. I understand the advantages of the Zeiss Well Vision Exam and decline at this time.

Voluntary Consent Form

Kraig J. Abe, O.D., F.A.A.O., F.I.A.O.M.C.
19665 Stevens Creek Boulevard, Cupertino, CA 95014-2422 USA
Phone: (408) 252-3662
Fax: (408) 350-7346 E-Mail: eyes@doctorabes.com

Consent to use or disclose health information for treatment, payment and health care operations.

Patient Name: ______________________________ Phone: ____________________

Patient Address: ____

SIGNING THIS DOCUMENT SIGNIFIES THAT YOU HAVE VIEWED OR RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

We have a comprehensive ***Notice of Privacy Practices*** that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this ***Consent Form***. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

______________________________ ______________
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

______________________________ ______________________________
Relationship to Patient Print Name

*Vision Insurance Company		Medical Insurance Company ☐ PPO ☐ HMO ☐Other	
Company:	Employer:	Company:	Employer:
Subscriber's Name:		Subscriber's Name:	
SS# of subscriber (last 4 digits):		SS# of subscriber (last 4 digits):	
Relationship:	DOB:	Relationship:	DOB:
Member ID:		Member ID:	
Group #	Policy #	Group #	Policy #

****Please complete above only if we don't already have this information***

1. Vision Care Plans vs Medical Insurance

Vision Care Plans

Coverage through most vision plans is designed to determine the prescription for spectacles and/or contact lenses only. This excludes additional diagnostic testing/procedures tests needed to determine any ocular ***medical*** conditions.

Medical Insurance

If a medical condition is present or diagnosed such as glaucoma, macular degeneration, diabetes, or high blood pressure, it is necessary to provide a comprehensive ocular ***medical*** examination. In this situation we will file a claim to your major medical insurance carrier. Generally most carriers will either cover or pay a portion of the diagnostic tests necessary to diagnose and treat the medical condition(s) related to your ocular health.

2. Pupillary Dilation of the Eyes

As part of your examination the doctor will recommend if your eyes should be dilated. Dilation is performed to enable the doctor to obtain a more comprehensive view of the structures inside the eyes. Dilation is recommended if you have a systemic condition that can directly affect the eyes such as diabetes, or take medications that can directly affect the eyes. Dilation is also recommended if you have been previously diagnosed with an ocular health condition.

The eye drops used for dilation will cause some light sensitivity and blurred vision when looking at a computer or reading for about four to six hours. The drops will generally not affect the ability to drive, though if you feel you may be uncomfortable driving, please bring a designated driver with you when having your eyes dilated.

Please inform us if you would like the eyes dilated.

initial ______ ☐ Yes, you may dilate my eyes today

initial ______ ☐ No, please do not dilate my eyes ☐ Please schedule a different day to have my eyes dilated

3. No Show / Missed Appointments

Please notify us as soon as possible if you need to cancel or reschedule an appointment as someone else may need the time we reserved for you. A $25 charge will be billed to your account for any missed appointments if 24 hours prior notice is not given.