

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. With over 40 years combined experience, our doctors specialize in Primary Care, Pediatrics and Low Vision. 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 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 OC Eye Designs. We are looking forward to meeting you. If you have any questions prior to your visit, or need to make a change to your appointment, please contact us at 714-545-9162.

Sincerely,

The OC Eye Designs Team

Here are just a few actual reviews posted on to Yellowpages.com by our patients.

**Customer Service That Money Can't Buy**

"There are few places you can walk into today where you're greeted with a genuine smile...keyword being GENUINE. The doctors and staff at OC Eye Design are truly the most genuine people, kind, intelligent and yes, they're even funny at times. The prices are competitive, but its the service that makes shopping for the latest in trendy eyewear an unbeatable deal. The doctors are also thorough and don't try to sell you things you don't need...they are truly concerned about your health and helping you make the most informed decisions about your healthcare options. Like the title says, overall what OC Eye Design brings that no other optometrist can, is customer service that money can't buy. Thank you OC Eye Design!"

**OC Eye Designs are great people!**

"Some of the friendliest and helpful eyecare professionals anywhere. Let's just say, I'll never use Lenscrafters again!"

**A satisfied customer**

"The wonderful people at OC Eye Designs not only have the friendliest staff, but the most comprehensive optical staff . They are all very caring and make you feel at home in their office. You will look and feel great about your glasses and contacts! I highly recommend this office to EVERYONE."

**Great Experience**

"Everyone at OC Eye Designs Optometry was excellent. They were all really nice and professional. It was a great experience and I would highly recommend them."

**Awesome Service**

"1) The Exam by Alissa Wald was expert, thorough, and not in the least bit hurried. 2) The service and fitting by Jen was also expert. 3) Erek followed up with me to make sure I was happy and went the extra yard to make sure Eye was :) Eye Shops simply don't get any better than this. Avoid the discount factory mills. You get what you pay for."

**Amazing Optometry Experience**

"Going to get your eyes checked may not always be the most pleasant experience and something that we can tend to put off and by the time I finally got around to deciding I needed to get my eyes checked and get new glasses for driving I arrived at Dr. Wald's office expecting your normal run of the mill eye exam experience. What I got was far from that, the staff at OC Eye Design were so very friendly. The doctor that I saw that day, Dr. Yang was very thorough, gentle and caring. I really felt like I knew exactly what the state of my vision was by the time we were done. The staff in the front were amazing, Jennifer helped me pick out my new frames and I love them!!! I got the transition lenses that I have been wanting since I first saw the ad for them! Overall this is an office that I recommend to others whole heartedly! Dr. Wald and her doctors are amazing."



PATIENT INFORMATION

PERSONAL INFORMATION - PLEASE FILL IN ALL FIELDS

Name: _____ **Sex:** M / F
LAST FIRST MIDDLE INT

Date of Birth: ____/____/____ **Social Security #:** ____ - ____ - ____ **Drivers License #:** _____

Mailing Address: _____
NUMBER & STREET CITY / ST ZIPCODE

Phone: Daytime (____) ____ - ____ Home (____) ____ - ____ Other/Cell (____) ____ - ____

Email Address: _____ **Occupation:** _____ **Employer:** _____

Whom may we thank for referring you to our office? _____

VISION Insurance Information:

VSP ____ Medical Eye Services(MESC) ____ EYEMED ____ SAFEGUARD ____ OTHER _____

MEDICAL Insurance Information (Regular Health Insurance Coverage, if applicable):

Insurance Name: _____ Member ID#: _____ Group #: _____

Primary Member's Name: _____ Primary Members Date of Birth: _____

Primary Member's Social Security Number: ____ - ____ - ____ Relationship to Patient: _____

****** PLEASE PRESENT MEDICAL INSURANCE CARDS TO FRONT DESK ******

AGREEMENT(S)

I authorize OC Eye Designs and staff to release any medical information necessary to my insurance company to process this claim. This authorization shall apply to all claims submitted on my behalf or for my dependants.

I also authorize payment of medical and/or vision insurance benefits to OC Eye Designs. I understand that I am financially responsible to OC Eye Designs for the charges not covered by my insurance as well as any deductible and/or coinsurance.

I understand and agree that payment is required at the time services are rendered.

Signed: _____ **Date:** _____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____

Date of Last Eye Exam _____ Dilated? Yes / No Referred By: _____

Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____

Diabetes Yes/No Type _____ Date of diagnosis _____

Allergies to Medication Yes/No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

Have you had any operations? Yes/No Kind? _____ When? _____

Name of family doctor _____

Date of last visit _____ Date of last tetanus shot _____

Family History

High blood pressure Yes/No Relation _____ Macular degeneration Yes/No Relation _____

Diabetes Yes/No Relation _____ Retinal detachment Yes/No Relation _____

Glaucoma Yes/No Relation _____ Cataracts Yes/No Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type _____

Additional information _____

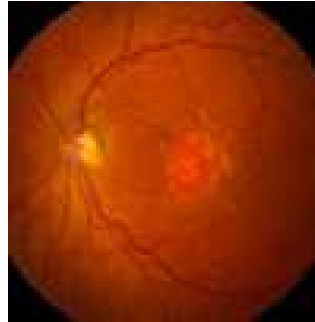
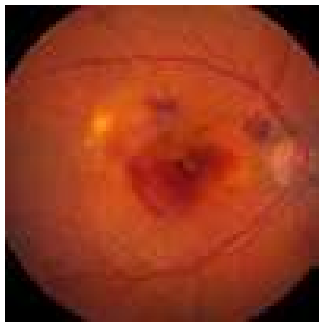
DIGITAL RETINAL SCREENING CONSENT

Our office offers high resolution retinal photography, which uses a computer-integrated digital imaging system to record a detailed view of the retina. This image provides an excellent reference point for future comparisons and records any changes.

We recommend that **all our patients** have this test. It is especially important for those with a history of and/or a family history of:

- ✓ Diabetes
- ✓ High blood pressure
- ✓ Glaucoma
- ✓ Macular Degeneration
- ✓ Retinal diseases
- ✓ Flashing lights
- ✓ Decreased or distorted vision
- ✓ A strong glasses prescription

Even if you see well, many retinal conditions **do not produce symptoms** such as pain or blurred vision. Retinal photography helps in early detection of retinal problems to avoid vision loss and preserve superior eye health.



The fee for this additional part of your eye exam is \$39. In most cases, this test is not covered under your medical or vision insurance. Upon request, this office will advise you of your coverage, and you may be required to submit a receipt for reimbursement from your insurance provider.

_____ **Yes, I want to have retinal photos taken as part of my eye exam.**

_____ No, I decline the recommendation to have retinal photos taken.

Signature: _____ Date: _____

Receipt of Notice of Privacy Policies & Consent Form

OC Eye Designs Optometry
1545 Adams Ave, Suite 100
Costa Mesa, CA 92626
(714) 545-9162

Patient Name: _____

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.

The *Notice of Privacy Practices* you have been given describes these use and disclosures in detail. You are free to refer to this notice at any time before you sign this 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 health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare 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 document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from OC Eye Designs Optometry.

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

Source of Authority: _____
PEN Publications 800-444-9230