Welcome To The Professional Practice Of Drs. Jenkins, Pham, & Ziskrout

Please fill out information pertaining to the patient. If you have any questions, please ask one of our caring staff for assistance.

PATIENT INFORMATION: Date: _____ Home Ph:_____ Work Ph:_____ Cell Ph:_____
E-mail: _____ May we communicate with you via e-mail? YES NO
Mr. Mrs. Ms. Dr. _____ _____ _____ _____
(PATIENT'S FIRST NAME) (M.I.) (LAST NAME) (NICKNAME)
Address: _____ Apt/Ste: _____ City/State/Zip: _____ Sex: M F
Date of Birth: ____/____/____ Social Security #: ___-___-____ State Drivers License # _____
Emergency Contact Person: _____ Relationship: _____ Phone: _____
Occupation_____ Number of Hours on Computer: _____
Employer: _____ Hobbies: _____
Additional Family Members Living At Home: Spouse: _____ Age: _____
Child: _____ Age: ____ Child: _____ Age: _____ Other: _____ Age: _____
Child: _____ Age: ____ Child: _____ Age: _____ Other: _____ Age: _____

GENERAL HEALTH HISTORY:
How Is Your General Health? _____ Environmental Allergies: _____
Current Medications: (Specify name, dosage, frequency. Example: Zocar, 5mg, Once daily) _____
_____
Known Medication Allergies: _____ Name of Family Doctor: _____,M.D. Last Visit: _____

	Yes	No		Yes	No		Yes	No		Yes	No
Diabetes	__	__	Cancer	__	__	Thyroid Problems	__	__	Use Cigarettes/Tobacco	__	__
Hypertension	__	__	Heart Problems	__	__	Are You Pregnant?	__	__	Use Alcohol?	__	__
Arthritis	__	__	Kidney Problems	__	__	Liver Problems	__	__	Other Substances?	__	__
Respiratory Problems	__	__	H.I.V. Positive	__	__	(If yes, please notify the doctor)					

OCULAR HEALTH HISTORY:
Reason For Today's Visit: _____ When Was It First Noticed?_____

	Yes	No		Yes	No		Yes	No	Family History
Sinus Problems	__	__	Double Vision	__	__	Glaucoma	__	__	_____
Headaches	__	__	Burn, Itch, Tear	__	__	Cataract	__	__	_____
Eye Injuries	__	__	Recent Eye Infection	__	__	"Lazy Eye"	__	__	_____
Eye Surgeries	__	__	Use Eye Drops	__	__	Macular Degeneration	__	__	_____
Light Flashes/Floaters	__	__	Name of Drops	_____		Retinal Detachment	__	__	_____

Date of Last Eye Examination: _____ Last Eye Doctor: _____

CONTACT LENS HISTORY:
Do you have or have you ever worn contact lenses: __No __Yes If yes, what type: __Soft __Rigid Gas Permeable __Toric __Bifocal __Other
Wearing Time Today: _____ hours Do you sleep in contact lenses (extended wear): __ No __ Yes If yes, how many days at a time_____
How often do you dispose them: __Daily __Two Weeks __ Monthly __Quarterly __Yearly __Never
Would you like new contact lenses today? __ No __ Yes: Which type _____

THIS SECTION MUST BE ANSWERED AND SIGNED

OPTOMAP: State-of-the-art technology that replaces eye drops and dilation. In 0.25 seconds, a full diagnostic scan of your retina is digitally mapped. The doctors educate and share their findings with you. This test is critical in the Early Detection of eye diseases like Glaucoma, Diabetes, Macular Degeneration, High Blood Pressure, Retinal Tears, Holes and Detachments, Certain Cancers and Tumors. The Optomap is also highly useful as a routine annual preventative eye health care. Currently, some insurance plans do not cover Optomap. **The Optomap fee is only $39.00**.

PUPIL DILATION: This test checks for the same serious eye conditions as above. We use eye drops that take about 20-30 minutes to fully dilate your pupils. Side effects are blurred vision up close and light sensitivity. It takes approximately 4-6 hours to recover from dilation. Unlikely side effects from dilation could be a sharp sudden rise in the pressure of your eyes, creating an ocular emergency. If we determine you are at risk for dilation or you are PREGNANT or NURSING, your pupils will not be dilated. You will usually be able to drive home comfortably.

I consent to: OPTOMAP Yes No X_____ DILATION Yes No X_____

METHOD OF PAYMENT: (Please Circle) Cash Credit Card Check (*Non-Sufficient Fund checks will incur a $30 non-refundable processing fee)*
~PLEASE NOTE PAYMENT IN FULL IS REQUIRED ON DAY OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE~

MEDICAL/VISION INSURANCE: YES NO (If yes, please circle one): Aetna, Block Vision, Blue Cross Blue Shield (BCBS), Cigna, Davis Vision, EyeMed, Medicaid, Medicare, Spectera, Superior Vision Plan, Tricare, United Health Care (UHC), Vision Benefit of America (VBA), Vision Care Plan (VCP), Other: _____

ASSIGNMENT OF BENEFITS: I hereby assign payment of authorized Medicare or other insurance to which I am entitled to be made to Drs. Jenkins, Pham, and Ziskrout for any services provided. This assignment will remain in effect and full force until revoked by me in writing. A photocopy of this assignment is deemed valid as is the original. I fully understand and accept that I am financially responsible for all fees and charges whether or not paid by your insurance provider. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature (Patient or Guardian): X_____ Date: _____

Referred by (circle please): Family Friend Doctor Radio TV Yellow Pages Website Newspaper Coupon Walk-In Health Plan
If you were personally referred, whom may we thank for the referral? _____