



Integrity Eye

Account # _____

Appointment Date: _____

Time: _____

Welcome to Our Office!

Patient Information for Medical Records - Integrity Eye

Please Print Clearly

Please Use Black Ink

Patient Name

Last:	First:	Middle Initial:	Phone:
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Mailing Address

Street:	City:	State:	Zip Code:
Birthdate:	Soc. Sec. #	Driver's Lic. #	Male Female
Email:	Cell:	Texting Ok:	Yes No
Employer Name:	City:	Work Phone:	
Occupation:			Age:
Primary Care Physician:	Marital Status:	Married Single Widowed Divorced	
Spouse's Name:	Soc. Sec. #	Birthdate:	
Spouse's Employer:	City:	Work Phone:	

Insurance Information for Responsible Person or Policy Holder

Last Name:	First Name:	Middle Initial:
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Home Address

Street:	City:	State:	Zip Code:
Relationship to Patient:	Home Phone:	Work Phone:	
Driver's Lic. #	Birthdate:	Soc. Sec. #	Male Female
Occupation:			Age:
Primary Insurance:	Policy or ID#:		
Secondary Insurance:	Policy or ID#:		
Vision Insurance:	3rd or other Ins. Info.:		
Referring Doctor:			
Other than your Doctor, how did you hear about us?			

I hereby authorize my doctor to provide information to my insurance regarding any illness or treatment. I understand that I am responsible for any charges, balances, or co-payments not covered by my insurance. I hereby assign my doctor all money to which I am or my heirs are entitled for medical services rendered.

I also understand that drops may be put into my eyes and that these drops may temporarily blur my vision for up to 48 hours. I understand that driving, reading, and other activities may be affected. Arrangements for a driver may have to be made.

Responsible Party Signature: _____

Date: _____

Patient's Name: _____ Date: _____

What problem/reason brought you to the eye doctor? _____

Name of general physician: _____

EYE HISTORY

Have you ever had:

- Yes No **Eye injury**
- Yes No **Cataract**
- Yes No **Glaucoma**
- Yes No **Macular degeneration**
- Yes No **Contact lenses**
- Yes No **Lazy eye**
- Yes No **Decreased vision**
- Yes No **Poor side vision**
- Yes No **Poor night vision**
- Yes No **Poor color vision**
- Yes No **Halos around lights**
- Yes No **Problems with glare**
- Yes No **Red eye**
- Yes No **Dryness**
- Yes No **Itching**
- Yes No **Mattering/Crusting**
- Yes No **Tearing**
- Yes No **Double vision**
- Yes No **Floaters**
- Yes No **Flashing lights**

- Yes No **Eye surgery (if yes, what type)**

Date of last eye exam: _____

Name and address of last eye doctor:

Please list any eye drops you are using:

What is (was, if retired) your occupation:

MEDICAL HISTORY

Have you ever had:

- Yes No **Arthritis**
- Yes No **Heart disease**
- Yes No **Diabetes**
- Yes No **Thyroid disease**
- Yes No **High blood pressure**
- Yes No **Lung disease**
- Yes No **Neurologic disease**
- Yes No **Liver disease**
- Yes No **Kidney disease**

- Yes No **Allergies (if yes, to what)**

Please list all medications you are presently taking:

Has anyone in your family had:

- Blindness (any type):** Yes No
- Glaucoma:** Yes No
- Cataract:** Yes No
- Macular degeneration:** Yes No
- Retinal detachment:** Yes No
- Diabetes:** Yes No

- Do you smoke?** Yes No
- Have you smoked for more than 1 year?** Yes No
- Do you drink more than 4 drinks per week?** Yes No

Sign below when you have completed this form to the best of your knowledge and are satisfied you understand its contents:

Patient or Responsible Party Signature

Relationship to Patient

Date



Integrity Eye

Arvind Saini, M.D.

Howard Krauz, M.D

Jean-Paul Abboud, M.D.

Gina Grasso, O.D.

1955 Citracado Parkway #301 Escondido, CA 92029

You will be receiving a comprehensive exam of your eyes which includes:

- A thorough medical evaluation of your eyes with dilated pupils
- Internal and external exam, papillary reflexes, ocular motility
- Tonometry (which determines the pressure of the eyes for possible glaucoma)
- Visual field screening (a screening test of your peripheral vision).

If you are seeing the optometrist you may also receive:

- A test for determining your eyeglass prescription (also known as a refraction)

The refraction portion of the exam is specifically excluded from most medical insurance, including Medicare and many secondary providers.

A refraction does not correct any eye disease and is unrelated to the health of the eye, therefore many insurance providers classify refractions as 'not medically necessary' and they exclude them from your insurance coverage.

There are many 'supplemental' vision insurance plans such as Vision Service Plan, Medical Eye Services and Secure Horizons, which will pay for both the comprehensive exam and the refraction. If you have a refraction done you will receive a copy of your eyeglass prescription.

Since there are so many insurance companies and each offer many different plans, it is impossible for us to know if your plan will cover your visit. We recommend that you check with your insurance company before your appointment if you have any questions about your coverage.

The cost for the refraction is \$45.00 and is due and payable by you on the day of the appointment.

If you do not have a medical diagnosis, you may be responsible for the total cost of the comprehensive exam as well which can vary from \$157 - \$181. We want to make sure that you are completely informed about the exam you will be receiving today. If you have any questions, please feel free to ask. Please also be aware that exams for contact lenses, laser surgery, and pediatric eye exams often require additional, more specialized tests and may incur additional charges.

Patient or Guardian Signature

Date

I ACKNOWLEDGE THAT I AM AWARE OF THE PRIVACY PRACTICES FOR INTEGRITY EYE ASSOCIATES, RELATIVE TO HIPPA.

Patient or Guardian Signature

Date