

WELCOME

OPTIX FAMILY EYECARE CENTER

DR. JOEL N. KESTENBAUM, Optometrist

PLEASE READ BOTH SIDES OF THIS FORM

SIGN AND INITIAL WHERE INDICATED

Patient Name: _____ Birth date: ___/___/___ Phone: (H) (____)____ - _____

Address: _____ Sex: M _____ F _____ (O) (____)____ - _____

_____ Occupation: _____ Cell (____)____ - _____

EMAIL: _____ Referred by: _____ Social Security #: _____ - _____

PAYMENT INFORMATION

Person responsible for payment: _____ Birth Date: _____ Relation to Patient: _____

Address: (if different) _____ Phone: (if different) (____)____ - _____

MEDICAL AND UNION INSURANCE INFORMATION: Please provide all information:

UNION or VISION Coverage: _____ Address: _____ ID # _____

Primary MEDICAL Insurance: _____ Address: _____ ID # _____

How much is your co-payment? \$ _____ or Deductible \$ _____

Additional MEDICAL Ins: _____ Address: _____ ID #: _____

Signature Authorization: I authorize release of any medical or other information necessary to process this or future claims to HCFA or its agents. I also authorize payment of Medicare or other medical benefits to Dr. Joel Kestenbaum or OPTIX Family Eyecare Center. I authorize use of my signature on all insurance forms. (If post cataract Medicare, I have been notified that I can choose a frame fully covered by Medicare and that I am allowed 1 pair of glasses per surgery, per lifetime.) I understand that I am responsible for payment of professional services and/or materials not covered by insurance or union benefits.

SIGNATURE: _____ **Date:** _____ [Dates 2 _____ Date 3 _____]

Do You or a Family member have a history of the following? If so, who?

Diabetes Cataracts
Hypertension Glaucoma
Thyroid Macular Degeneration
Arthritis Blindness
Have you ever had eye surgery? Y N For What? _____

Please check all that apply to you:

Headache Light Sensitive
Red Eyes Floating Spots
Dry Eyes Flashes of Light
Crusty Lids Itchy Eyes
Squinting Double Vision

Please List Your Allergies: _____ Smoker? Y N Alcohol Y N

Please List Your Current Medications: _____

PLEASE CHECK ALL THAT APPLY

Computer User Racquetball Fishing Skiing Golfer Swimming
Sun Worshiper Baseball Boating Sewing Tennis Reading
Do you spend much time outdoors? Y N Are you bothered by glare? Y N

Are you interested learning about **LASER VISION CORRECTION** for Yourself? Y N For Someone Else? Y N

Are you interested in **Contact Lenses?** Y N Have you worn Contact Lenses? Y N Hard, Soft, Other?

Name of Physician: _____

School Nurse: _____

Address: _____

Address: _____

Telephone: (____)____ - _____

Telephone: (____)____ - _____

THANK YOU IN ADVANCE FOR REFERRING A FRIEND

INFORMATION ON MEDICAL INSURANCE PLANS

Medical insurance will only pay for medically related eye examinations which require a medical diagnosis. If the main reason for your visit is for a routine/yearly eye exam or contact lens check-up, your insurance plan may not pay and the patient is responsible for this fee.

Most insurance plans DO NOT pay for refractions (the part of the exam that checks for eyeglass prescriptions). The patient is responsible for this part of the fee.

Most medical insurance carriers and union plans do not pay for a contact lens evaluation or a contact lens fitting. The patient is responsible for this part of the fee.

Please initial _____

ABOUT OUR CONTACT LENS SERVICES

At OPTIX Family Eyecare Center our goal is to provide all our patients with the best in professional eyecare. This philosophy also applies to our contact lens care. We use state-of-the-art instrumentation to ensure accurate testing when measuring our patients for contact lenses. We also use a wide variety of contact lenses which helps us to successfully fit the vast majority of our patients who would like to wear contact lenses.

Your contact lens experience begins with a thorough eye health examination. This examination will help determine if you are a contact lens candidate.

If, after the examination, it is determined you are a suitable contact lens candidate, **additional fitting services** are provided. These fitting services include the following care:

- **Counseling** as to your contact lens options based on the measurements taken as part of the contact lens examination.
- **Dispensing instructions** from a contact lens technician. You will receive insertion and removal instructions including practice contact lens handling during this session.
- An initial supply of **contact lens solutions**. You will receive all the necessary solutions to get you started in the proper care of your contacts. (if needed)
- **Follow-up evaluations**. We will take good care of you after you have your contacts. Our emphasis on proper follow-up care is what distinguishes us from other offices. We want to ensure your contact lens success!

Our **Contact Lens Professional Fitting Fees** will depend on the estimated professional time needed to fit you properly with the appropriate lens. The professional fee will be discussed on a per case basis. **Contact Lens Material Fees** are additional.

Please note that if a patient does not continue with contacts after a 1 month fitting period, all material costs, except for certain bifocal contact lenses and “opened boxes of contacts (if disposables),” will be credited towards any future service at OPTIX.

For your convenience, OPTIX offers fast home or office delivery of most contact lenses. Simply call us 24/7 when it is time to reorder.

Our Contact Lens Replacement Fees are lower than most internet vendors.

Please initial _____