WELCOME TO OUR OFFICE

Patient Name: ______________________________ **Date** ______________

Who is your Medical Doctor? ______________________________

Patient Medical/Ocular/Social History

Are you allergic to medications? ___ Yes ___ No **List:** ______________________

Do you wear contact lenses? ___ Yes ___ No **Hard or Soft?** ______ **Brand Name:** ______ ______

When was your last eye exam? __________ **with** ______________________ **M.D. or O.D.**

Do you drive? ___Yes ___No / **Comment:** ______________________

Do you smoke? ____ Yes ____ No **If Yes, How many years?** __________
Do you drink alcoholic beverages? ____ Yes ____ No **Circle one:** Social Moderate Heavy

Please put an "X" next to the condition you have or put an "X" next to "NKMC"

Medical

___ **NO KNOWN MEDICAL CONDITIONS**
___ High Blood Pressure
___ Diabetes
___ Thyroid Problem
___ Asthma
___ Heart Problem
___ Other: __________

Ocular

___ **NO KNOWN MEDICAL CONDITIONS**
___ Cataracts
___ Glaucoma
___ Retinal Problems
___ Macular Degeneration
___ Trauma : __________
___ Other: __________

Family Medical History:

Does anyone in your Family have any of the following conditions:

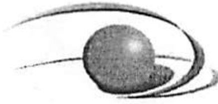
		Mother	Father	Sister(s)	Brother(s)	Other
___	NOT TO MY KNOWLEDGE	☐	☐	☐	☐	☐
___	High Blood Pressure	☐	☐	☐	☐	☐
___	Diabetes	☐	☐	☐	☐	☐
___	Thyroid Disease	☐	☐	☐	☐	☐
___	Glaucoma	☐	☐	☐	☐	☐
___	Other: __________	☐	☐	☐	☐	☐

Patient Medication List

Medication/Drops	Dosage	Times per day	Medication/Drops	Dosage	Times per day

Patient Surgical History

Type of Surgery/ Hospitalization	Date	Doctor


Eye Physicians of Virginia

Glaucoma Consultants ● Neuro-Ophthalmic Consultants ● Oculoplastics ● Refractive Cataract Surgery
Lasik ● Comprehensive Ophthalmology

Kenneth M. Karlin, M.D.   A. Catherine Schwartz, M.D.   Brian M. Egan, M.D.   Faheem Ahmed, M.D.

6845 Elm St. Suite 611 McLean,VA
Tel: 703-356-6880
Fax: 703-893-7336
eyemclean@aol.com

1800 Town Center Dr. Suite 317 Reston, VA
Tel: 703-437-3900
Fax: 703-437-9426
eyephysiciansva@aol.com

www.eyephysiciansofvirginia.com

NOTICE OF NONCOVERED REFRACTION SERVICES TO PATIENTS

Definition of REFRACTION: The refraction test is an eye exam that measures a person's ability to see an object at a specific distance. The ophthalmologist can determine if you have nearsightedness, farsightedness, astigmatism (asymmetrical cornea), or presbyopia (inability to focus on objects that are close to you). The extent of vision difficulty can be determined. The information obtained from a refraction test allows the prescription for eyeglasses or contact lenses to be correct for each person. **This test can be done as part of a routine eye test to determine if a person has normal vision. When a person complains of blurred vision, this test can help determine the extent of poor vision. It can also be performed to help follow the progress of treatments for diseases of the eye such as cataracts. The test is also used to prescribe glasses if needed.**

Medicare and most commercial insurance plans do not cover the above mentioned service. If you choose to have the refraction done and your insurance does not pay for it you will be held responsible for paying that portion of the exam fees along with any other fees you are normally responsible for (i.e. co-payments/deductibles).

By signing, I understand that the refraction may not be covered service under my health insurance plan. If I want a glasses prescription update/renewal, I agree to pay the $75.00 refraction-fee related to this non-covered service along with any other fees required by my insurance plans (co-payments or deductibles)if it is NOT covered.

Patient Signature: ______________________ **Date:** ____________________