NAME____ **SEX** M / F **AGE** ______ **DATE** _____/_____/______
CC____
PEH____
PMH____
FEH____SH_______________
FMH____

UNAIDED DIST VA		**PINHOEL VA**	**CURRENT RX**		**ADD**_______
	OD 20 / ____	OD 20 / _____	**RX** OD_______________	DATE 20	TYPE
	OS 20 / ____	OS 20/ _____	OS________________	20	
	OU 20 / ____				

NCT________ **TIME**	**COLORVISION**	**STEREO**	PD	**KER**
OD _________ mmHg	OD WNL DEF		___________	OD _______________
OS ___________	OS WNL DEF		NPC	OS ________________

API_____ **TIME**	**PDI**	**PUPILS**	**COVER**	**OCULAR MOTILITY**	**CONF FLD**
OD_____mmHg	OD_____mmHg				OD WNL
OS______	OS______	P RRLA		F + S	OS WNL

AUTOREF OR RETINO	OD___________________________20/______	**DIST**	OD_________________________20/____
	OS___________________________20/______	**SUBJ**	OS_________________________20/____
NEAR	OD___________________________20/______	**LAT**	OD_________________________20/____
ADD	OS___________________________20/______	**PHOR**	OS_________________________20/____

CCT OD_______________u OS_______________u **BP**:____________________W:_________H:_________

EXTERNAL BIOMICROSCOPY

ANGLE EST
OD 1 2 3 4
OS 1 2 3 4

OD OS
WNL WNL
☐ ☐ TEARS
☐ ☐ LID/LASH
☐ ☐ CORNEA
☐ ☐ PAL CON
☐ ☐ BUL CON
☐ ☐ ANT CHB
☐ ☐ LENS
☐ ☐ IRIS
☐ ☐ ANT VIT

INTERNAL DO BIO 90D
1ggt 1% Trop + 2.5% PE

C/D
OD_____
OS_____

OD OS
WNL WNL
☐ ☐DISC MARGINS
☐ ☐MACULA
☐ ☐VESSELS
☐ ☐BACKGROUND
☐ ☐MEDIA
☐ ☐VITEROUS
☐ ☐PERIPH RET
(BIO-DILATED)

☐ RETINAL IMAGING

DIAGNOSTIC LENSES

OD__________________________________ **OS**__________________________________
____
____
ORDER____

ASSESMENT
____
____
____
PLAN__________________________________
____
____

SRN
OD______________________________ADD___________
OS____
CLRN
OD____
OS____

NEXT APT: **SIGNATURE:**

CONTACT LENS FOLLOW UP **DATE:**
CC:
VA (CL)
SLE:
GOOD FIT & HEALTH-RELEASE RX ☐

☐Patient was instructed on CLS care and I&R
☐Patient was warned of possible risks of CLS wear

"We take your eyes to heart"

Dr. Mehdi Kazem
WELCOME TO OUR OFFICE
www.drkazemeyecare.net

OFFICE USE ONLY
APPT______________
GL_______CL______
TY___________DST ☐

Please fill out the information requested so that we may better serve you. Please print. Thank You!

Name:____ Date of Birth: ____/____/____ Age: _________
Last First MI

Address: ____ Sex: ☐ Male ☐ Female
Pregnant? ________________________
Breast Feeding? ____________________
____ Occupation:________________________
City State Zip SS#___________________________

Phone# Home:______________________ Business:______________________ How did you hear about our office?

Cell: ______________________ Text: ☐Yes ☐ No

☐Insurance ☐Referral ☐Internet
☐Location ☐Previous Patient ☐Other
Email: ___________________________

____
Person to notify in case of emergency Relationship Phone#

Reason for Today's Visit: ☐General Eye Exam ☐Contact Lens Exam ☐Office Visit/Emergency

Last Eye Exam: ☐Less than 1 year ☐1-2 Years ☐2-5 Years ☐Over 5 Years ☐Never

Please check yes or no if you have or ever had any of the following:

Yes	No		Yes	No	
☐	☐	Glaucoma	☐	☐	Any immediate family with any of these conditions? If answered "Yes" to any of these questions please explain below:
☐	☐	Cataracts			
☐	☐	Eye Injuries			
☐	☐	Eye Surgeries			
☐	☐	Amblyopia (Lazy Eye)			
☐	☐	Strabismus (Crossed Eye)			
☐	☐	Color Vision Problems	☐	☐	Are you currently taking any OTC or prescription medication and/or vitamins and herbs?
☐	☐	Other Eye Problems			
☐	☐	Diabetes			
☐	☐	High Blood Pressure			
☐	☐	Allergies			
☐	☐	Drug Sensitivities	☐	☐	Allergies to any Medications:
☐	☐	Thyroid Problems			
☐	☐	Cancer			

Please read the information on the following tests and dilation on the clip board before answering the following questions. Technician will explain further.

I would like the following tests done ☐Digital fundus photo ☐Visual field ☐Topography ☐All three tests ☐ None

I would like my eyes dilated ☐Yes ☐No

Are you interested in refractive surgery? ☐Yes ☐No

We are a provider for a selected number of medical and vision plans. We will be happy to process the claims for insurance plans with which we participate. However, it is your responsibility to provide us with a copy of your insurance card so we may obtain authorization before your appointment. You will be responsible for any co-pays or contact lens fitting fees that your insurance does not cover at the time of your visit. All contact lens exams include two month follow up care. There will be an office visit fee for any appointments outside this period. As a result, it is very important that you keep your follow up appointments.

I the undersigned, have read and understand the office policy stated above and agree to accept responsibility as described.

HIPPA Acknowledgement/Privacy Practice Notice. I have been shown and understand the Notice of Privacy Practices of LFE.

Signature: ______________________________________ Date: ____________________