PAUL L. TREGER, M.D. **GLENN B. COOK, M.D., PhD**
RANDALL CONRAD, O.D. **TARA BROWN, M.D.**

5555 RESERVOIR DRIVE SUITE 300 – SAN DIEGO, CA 92120
619.286.9077 – 619.286.3711 – FAX 619.286.2184

Dear

Please allow us to welcome you to our practice. Our first priority is to provide you with the best care possible.

Enclosed is your patient information sheet and medical history questionnaire. Please complete then and bring them with you on the date of your appointment.

Please also bring with you a list of current medications, your health insurance card(s) and your glasses.

If you should need to reschedule your appointment for any reason, please give us at least 24 hours notice.

We look forward to serving you.

Paul L. Treger, MD
Glenn B. Cook, Md, PhD
Randall Conrad, OD
Tara Brown, MD

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PLEASE REVIEW FOR ACCURACY AND COMPLETE WHERE APPROPRIATE

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex: F
City:	Usual Provider: GLENN COOK
State: Zip:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	
City:	Employer:
State: Zip	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Alvarado Eye & Paul Treger when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, Alvarado Eye & Paul Treger to release any information necessary for my course of treatment.

_____________________________________ ________________

Signed (patient or parent if minor) Date

PAUL L. TREGER, M.D., F.A.C.S
GLENN B. COOK, MD, PhD

Medical History Form

TODAYS DATE:________________

PATIENT NAME________________

FAMILY (PRIMARY) PHYSICIAN________________PHONE #(____)_________________

DO YOU HAVE ANY CURRENT MEDICAL PROBLEMS? PLEASE EXPLAIN

____

CURRENT MEDICATIONS / CURRENT EYE MEDICATIONS

CURRENT MEDICATIONS	CURRENT EYE MEDICATIONS
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________

ALLERGIES YES NO

PLEASE LIST ____

MEDICAL SYSTEM REVIEW
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

( ) HIGH BLOOD PRESSURE
( ) DIABETES
( ) BREATHING PROBLEMS
( ) MIGRAINE HEADACHES
( ) HEART PROBLEMS
( ) ANEMIA
( ) CANCER OF ANY KIND
( ) KIDNEY DISORDER
( ) THYROID DISEASE
( ) STROKE
( ) SKIN DISORDER
( ) INTESTINAL DISORDER

PRIOR SURGERIES (INCLUDING EYE SURGERY)

______________________________ ______________________________

FAMILY HISTORY: FAMILY MEMBER:

( ) DIABETES ______________________________
( ) HEART DISEASE ______________________________
( ) HIGH BLOOD PRESSURE ______________________________
( ) CANCER ______________________________
( ) CATARACTS ______________________________
( ) GLAUCOMA ______________________________
( ) RETINAL DISEASE ______________________________
( ) BLINDNESS ______________________________

SOCIAL HISTORY

( ) SMOKER PACKS PER DAY ____________
( ) ALCOHOL USE AMOUNT PER DAY___________

OCCUPATION____

EYE HISTORY:

( ) CONTACT LENSES IF YES WHAT TYPE? ____________________

PREVIOUS EYE SURGERY: (PLEASE PROVIDE DATES)

CATARACT R___________ L___________

LASER R___________ L___________ WHAT TYPE ___________

GLAUCOMA R___________ L___________

OTHER R___________ L____________ WHAT TYPE ___________

EYE SYSTEM REVIEW:

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS:

( ) COMPLETE OR PARTIAL LOSS OF VISION
( ) CATARACTS
( ) GLAUCOMA
( ) MACULAR DEGENERATION
( ) EYE DISEASE FROM DIABETES
( ) IRITIS OR INFLAMMATION INSIDE THE EYE
( ) DRY EYES
( ) EYELID INFECTIONS (BLEPHARITIS)
( ) LAZY (AMBLYOPIC) EYE
( ) CROSSED OR DEVIATED EYES
( ) DOUBLE VISION
( ) GROWTHS ON EYELIDS OR EYES
( ) EYE INJURY
( ) CONSTANT TEARING OF EYE(S)

WHAT IS THE PURPOSE OF TODAY’S EXAM?

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PAUL L. TREGER, M.D. **GLENN B. COOK, M.D.**
Tara L. Brown, M.D. Randall Conrad, O.D.

TO OUR PATIENTS

Refraction

The portion of an eye exam known as a "Refraction" is not covered by most insurance companies (including Medicare). This part of the examination is done to determine your current need for glasses.

The charge for the "Refraction" is $35.00. If you do not wish this optional portion of the examination to be performed, please inform the technician at the beginning of the exam.

If you wish to have this portion of the exam completed, and it is known that your insurance will not cover it, you will be asked to pay the $35.00 charge upon completion of your examination.

No Show/ Canceled Appointment Policy

If you fail to give our office 24 hour notice of cancellation of your appointment we reserve the right to charge you $25.00 for your appointment time.

Returned Check Fee

$25.00 Service charge

Collection Services

$50.00 Administration Fee will be added to the account

Form Fee

$10.00 Administration Fee for forms required to be completed by Physician
Insurance Patients (PPO or HMO)

You agree to assume full financial responsibility for all medical services provided to you in the event it is determined by the insurance carrier that you were ineligible for benefits at the time of service, did not provide correct insurance information, or the service was not covered.

_______________________________ ________________
Signature Date

____
Print Name