



DR. MEHDI KAZEM
WELCOME TO OUR OFFICE

"We take your eyes to heart"

www.drkazemeyecare.net

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: _____
 SS#: _____
 City State Zip
 Phone # Home: _____ Business: _____
 How did you hear about our office?
 Insurance Referral Internet
 Location Previous Patient Other
 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
 I Do I Do Not Give permission for diagnostic drops to be used in my eyes. (You may discuss this with the doctor before deciding.)

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

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

Have you ever worn contact lenses? If yes, what type: Hard Rigid gas permeable Soft Disposable
 Yes No How worn: Daily wear Extended wear Flexible wear
 Are you interested in refractive surgery? Yes No

Name of Vision Insurance Plan: _____ ID# _____
 Name of Medical Insurance Plan: _____ ID# _____ PPO HMO



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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.

Signature: _____ Date: _____

Dr. Kazem is an independent Doctor of Optometry. Therefore, his practice is separate from the vision center, as are his fees. Please make checks payable to Dr. Kazem.