JEANNINE SCHEINHORN, M.D.
DIPLOMATE AMERICAN BOARD OF OPHTHALMOLOGY

Welcome to our practice!

Dear _____:

We would like to welcome you to our office and thank you in advance for giving us the opportunity to participate in your eye care needs. **Please pay particular attention the emboldened passages below.**

Your appointment is scheduled as follows:

Day: _____Date: _____Time: _____ a.m. / p.m.

Please arrive a few minutes prior to your appointment time for registration purposes; **AND bring with you the enclosed patient information sheet (completed), your insurance card(s), referral, co-pay if applicable, a list of all medications you are currently taking and your current eyeglasses or contact lenses.**

Be advised that we **perform a refraction in addition to our normal examination and testing. A refraction is part of the eye examination that determines your best visual acuity and is the basis for providing your prescription for glasses.** However, the issuance of a prescription is not necessary to validate the service. The doctor uses that information along with other tests to determine your overall eye health. **The $50.00 cost of a refraction is not covered by Medicare and most insurance plans, and is due at the time of your appointment, unless you are insured by a vision plan such as VSP.** If you require a contact lens prescription, our licensed contact lens fitter will provide one at an additional cost.

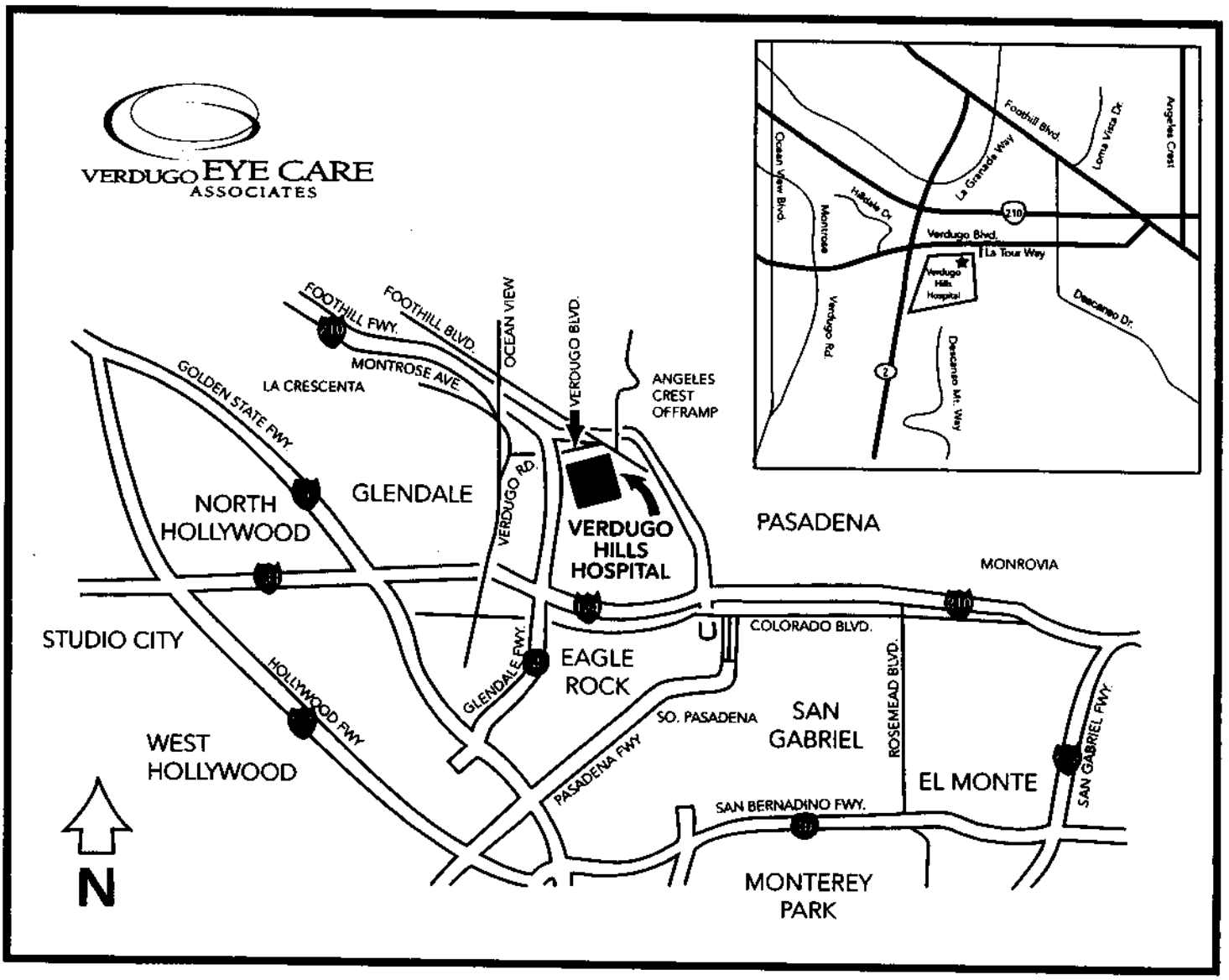
We will be happy to bill most insurance plans as a courtesy to you. If your insurance plan requires a form, please bring it to the appointment (this does not apply to VSP; we will obtain benefits for you). Our office is conveniently located off the 2 Freeway North (Verdugo BOULEVARD exit, **NOT** Verdugo ROAD) at 1808 Verdugo Boulevard, Suite 103, Glendale, California 91208. We also offer free convenient parking in front of the Verdugo Medical Building. For your convenience, we have enclosed a map.

We look forward to meeting you at the scheduled time. If we may be of any further assistance, please feel free to call at (818) 790-0702.

Dr. Scheinhorn & Staff

VERDUGO EYE CARE ASSOCIATES
1808 VERDUGO BOULEVARD, SUITE 103
GLENDALE, CALIFORNIA 91208
TEL 818.790.0702 FAX 818.790.2708
WWW.VERDUGOEYECARE.COM

Map and Directions to Dr. Scheinhorn



From the East (Pasadena, Monrovia, Rosemead), take the 210 West and exit on Angeles Crest. Turn left on Angeles Crest (away from the mountains). Turn right on Foothill. Turn left on Verdugo Blvd. Turn left on La Tour Way into our parking lot.

From the West (La Crescenta, Sunland, Tujunga), take the 210 East and exit on Ocean View Blvd. Turn right on Ocean View (away from the mountains). Turn left on Montrose. Turn left on Verdugo Blvd. Turn right on La Tour Way into our parking lot.

From the South (Glendale, Eagle Rock, or Los Angeles), take the 2 freeway North. As you approach the 210 Freeway interchange, get in the far right lane. Exit toward the 210 East/Pasadena ramp and exit on Verdugo Blvd. (not Verdugo Road). Turn right onto Verdugo Blvd. Turn right on La Tour Way into our parking lot.

1808 Verdugo Boulevard, Suite 103
Glendale, California 91208
Telephone (818) 790-0702 Fax (818) 790-2708

VERDUGO EYE CARE ASSOCIATES

PATIENT INFORMATION – PLEASE PRINT

TODAY'S DATE: _____ FAMILY PHYSICIAN: _____

REFERRED BY: _____ PHYSICIAN ADDRESS: _____

PHONE NO.: _____

1. LAST NAME FIRST NAME INITIAL MR. MRS. MISS	14. NAME OF EMPLOYER
2. STREET ADDRESS	15. ADDRESS
3. CITY STATE ZIP	16. OCCUPATION
4. DATE OF BIRTH AGE MO DAY YEAR	17. NAME OF SPOUSE
5. SEX MARITAL STATUS n MALE n FEMALE M S W D	18. SPOUSE'S EMPLOYER
6. SOCIAL SECURITY NO.	19. SPOUSE'S EMPLOYER'S ADDRESS
7. HOME / CELL PHONE WORK PHONE ( ) ( )	20. PHONE NUMBER ( )
8. MEDICARE MEDICARE NUMBER n YES n NO	21. NAME OF RESPONSIBLE PARTY PHONE NUMBER ( )
9. MEDI-CAL MEDI-CAL NUMBER n YES n NO	RESPONSIBLE PARTY'S ADDRESS
10. OTHER INSURANCE COMPANY	CITY STATE ZIP
11. GROUP NUMBER MEMBERSHIP NUMBER	22. NEAREST RELATIVE (NOT LIVING WITH YOU) PHONE NUMBER ( )
12. OTHER INSURANCE COMPANY	23. NAME OF NEAREST FRIEND
13. GROUP NUMBER MEMBERSHIP NUMBER	24. DRIVER'S LICENSE NUMBER

THE DILATING DROPS USED IN YOUR EYES AS PART OF THE EXAMINATION MAY BLUR YOUR VISION AND MAKE IT UNSAFE TO DRIVE. PLEASE DO NOT ATTEMPT TO DRIVE UNTIL YOU ARE CERTAIN THE EFFECT OF THE MEDICINE HAS WORN OFF. THE EFFECT OF THE DROPS USUALLY LASTS ABOUT ONE HOUR.

IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED.

MEDICARE LIFETIME ASSIGNMENT AUTHORIZATION

Name of Beneficiary _____

HIC Number _____

I request that payment of authorized Medicare benefits be made to (physician's name) on my behalf for any services furnished me by that physician. I authorize any hold of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services.

Beneficiary Signature _____ Date _____

MEDIGAP AUTHORIZATION

Beneficiary Name _____

HIC Number _____

I request the payment of authorized Medigap benefits be made to (physician's name) on my behalf for any services furnished to me by that physician. I authorize any hold of medical information about me to release to (name of Medigap insurer) any information needed to determine these benefits or the benefits payable for related services until this authorization is revoked.

Beneficiary Signature _____ Date _____

Nearest Relative In Case of Emergency _____ Relationship to Patient _____

Address _____ City _____ State _____ Phone (_____) _____

AUTHORIZATION AND ASSIGNMENT

I authorize Jeannine Scheinhorn, M.D., a medical corporation, to provide care and treatment and to release medical information that may be requested by insurance companies to whom I have submitted a claim, and hereby request _____ Insurance company, to pay Jeannine Scheinhorn, M.D., a medical corporation, 1808 Verdugo Blvd., Suite 103, Glendale, CA, all benefits accruing to me under my Surgical, Hospitalization and Medical Plan. I understand I am financially responsible to the physician for all charges not covered by this assignment.

Signature _____ Witness _____

ELIGIBILITY GUARANTEE (PRE-PAID PLANS ONLY)

I, _____, hereby certify that I am eligible for the Health Maintenance Organization mentioned above and that I have chosen as my participating medical group. I understand that if I am not eligible or have not received prior authorization, I am responsible for all charges for services rendered

CASH BASIS ONLY

I understand I am financially responsible to Jeannine Scheinhorn, M.D., a medical corporation, for all charges for services rendered

Signature _____

Date_____

Name_____Age_____

Yes	No	Your Medical History
___	___	Are you allergic to any medication? If so what?_____
		_____
		What kind of reaction do you have?_____
___	___	Do you have alcoholic drinks more than 3 times a week? If yes, how much do you drink?_____
___	___	Do you smoke? If so how many cigarettes per day _____. Number of years _____

WHAT OPERATIONS HAVE YOU HAD AND THE APPROXIMATE YEAR

_____

_____

_____

Yes	No	HAVE YOU EVER HAD?	IF YES, WHEN?
___	___	**Arthritis**	_____
___	___	**Asthma/Emphysema**	_____
___	___	Lung disease	_____
___	___	Tuberculosis	_____
___	___	**Bleeding tendency**	_____
___	___	Aspirin/Blood thinner	_____
___	___	**Cancer**	_____
___	___	**Cholesterol**	_____
___	___	**Diabetes**	_____
___	___	**Ear/Nose/Throat disease**	_____
___	___	**High Blood Pressure**	_____
___	___	**Heart Disease**	_____
___	___	**Heart (Attack)**	_____
___	___	Irregular heart rate?	_____
___	___	Congestive Heart Failure	_____
___	___	Blindness for any reason	_____
___	___	Cold sore/Herpes of eye	_____
___	___	Eye injury	_____
___	___	Glaucoma	_____
___	___	Macular Degeneration	_____
___	___	Eye Surgery	_____

Yes	No	HAVE YOU EVER HAD?	IF YES, WHEN?
___	___	**Gastrointestinal disease**	_____
___	___	Liver Disease	_____
___	___	Hepatitis (yellow jaundice)	_____
___	___	**Kidney Disease**	_____
___	___	**Mental Disease**	_____
___	___	**Alzheimer's**	_____
___	___	**Nerve paralysis**	_____
___	___	**Neuro/Psychological**	_____
___	___	Headaches/Migraine	_____
___	___	Seizures	_____
___	___	Skin Disorders	_____
___	___	Stroke	_____
___	___	Thyroid Disease	_____
___	___	Other	_____

FAMILY HISTORY:

___ ___ Glaucoma _____

___ ___ Macular Degeneration _____

___ ___ Hereditary Eye Disease _____

List of all medication taken – prescribed by your doctor including **eye drops**, **injections** and **inhalers**. Also all over the counter medications including **vitamins** or **you may attach a typed or printed copy of your medication list.**

Medication Taken	How Often	Strength

Patient Signature: _____

Guardian: _____

JEANNINE SCHEINHORN, M.D.
DIPLOMATE AMERICAN BOARD OF OPHTHALMOLOGY

PATIENT UPDATES

Patient Name: _____

Current Address: _____

Primary Care Physician: _____

Email Address: _____ **(or check to opt out)** _____

Race/Ethnicity: _____

Primary Language: _____

Pharmacy: _____

Pharmacy Address: _____

Preferred Method of Receiving Confidential Communication:

- ☐ **Home Phone:** _____
- ☐ **Cell Phone:** _____
- ☐ **Patient Portal (email address needed)**
- ☐ **Regular Mail**

Patient Signature: _____ **Date:** _____

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