SUMMIT
Optometric Center

Justin T. Abo, O.D. & Lauren A. Abo, O.D.
15290 Summit Avenue, Suite C
Fontana, CA 92336
Phone: (909) 646-9800 Fax: (909) 646-9111
Website: www.visionsource-summit.com
E-mail: summitoptometric@yahoo.com

Welcome Back to Our Office

In order to keep your medical file up-to-date, please complete this page. Thank You!

Title: Dr. / Mr. / Mrs. / Ms. /Master /Miss / Rev. / Judge
Name:_____
Home address:_____
City:_____ State: ____ Zip: _____
Home phone: (_____)_____
Work phone: (_____)_____
Cell phone: (_____)_____
E-mail address: _____

Today's date: _____
Date of Birth: _____ Age: _____
Social Security #/School ID #: _____
Employer (or School): _____
Occupation (or Grade): _____
Status: Married / Divorced / Single / Widow(er)
Have you visited us on the Internet? Y N
www.visionsource-summit.com

Updated Health Information

Vision Insurance: _____
Medical Insurance: _____

Type: PPO / POS / HMO / Medicare Part B / Other: _____
Do you participate in a Flexible Spending Account? Yes / No
Family Physician/Internist Name: _____
Date of Last Visit: _____

Allergies to Medications: _____
Are you planning on getting new glasses today? Yes / No / If there is a change
Are you interested in contact lenses today? Yes / No

Personal Medical History/Current Medications:

Allergies:_____
Arthritis: _____
Cholesterol: _____
Diabetes: _____
Eye Injury/Disease: _____
Heart: _____
High Blood Pressure: _____
Surgery: _____
Other(s)_____

Females: Are you currently pregnant or breastfeeding? Yes / No

Are you experiencing any of the following symptoms?

- ☐ Blurry Vision
- ☐ Dizziness
- ☐ Double Vision
- ☐ Dry Eye(s)
- ☐ Flashing Lights
- ☐ Floaters / Spots
- ☐ Glare / Halos
- ☐ Grittiness /Sandy
- ☐ Headaches
- ☐ Itchy Eye(s)
- ☐ Light Sensitivity (Photophobia)
- ☐ Red Eye(s)
- ☐ Stinging / Burning
- ☐ Stye
- ☐ Tearing / Teary eye(s)
- ☐ Trouble seeing while driving

Family Medical History:

Blindness	Yes / No / Unsure
Cataracts	Yes / No / Unsure
Diabetes	Yes / No / Unsure
Glaucoma	Yes / No / Unsure
High Blood Pressure	Yes / No / Unsure
Macular Degeneration	Yes / No / Unsure

Other disease(s): _____

I acknowledge that I have received a copy of Dr. Justin T. Abo & Dr. Lauren A. Abo's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, www.visionsource-summit.com.

Patient name _____ Today's Date _____
Signature of patient (or parent/guardian for minors) _____

Thank you!

 02/10

SUMMIT

OPTOMAP DIGITAL EYE IMAGING TECHNOLOGY

Summit Optometric Center is pleased to offer you and your family the most highly advanced technology available in eye disease detection, the Optomap Digital Retinal Imaging. The digital imaging system allows us to thoroughly evaluate your internal eye health with dramatically improved precision that includes a depth in the retina not seen with a regular dilation.

Our Doctors are concerned about retinal disease such as macular degeneration, glaucoma, retinal detachments, and diabetic retinopathy; all which can lead to partial loss of vision or blindness. Additionally, systemic diseases such as diabetes and high blood pressure can be detected with a retinal examination. Eye exams with the retinal evaluations can be help you safeguard both your eyesight and general health.

OUR DOCTORS RECOMMEND OPTOMAP FOR THE FOLLOWING REASONS:

Optomap Retinal Imaging Provides:

- The ability to show you your retinal images today, during your exam.
- An In-Depth view of your retina (where disease can start).
- A permanent record for your medical records, which gives your doctor a comparison for diagnosing and tracking retinal disease.

Optomap Retinal Imaging is:

- Fast, easy and comfortable.
- Patient Friendly.
- ***Eliminates the need to be dilated, in most cases.***

Our doctors are committed to providing you and your family the highest standards of eye care available and recommend Optomap annually. With an annual Optomap, our doctors can track your eye health for concern, comparison and treatments. Because this technology is new, it is not covered by insurance and there is a **$29.00** fee for adults (18 years and over) / **$19.00** fee for minors for this procedure. (*Please advise staff if you have a history of epilepsy)*

_____ I elect to have an Optomap Digital Retinal Image of my retina.

_____ I DECLINE the Optomap Retinal Imaging and I am choosing to be dilated.

_____ I DECLINE BOTH THE Optomap and dilation. I understand that the potential for partial or total loss of vision may exist due to an undetected eye disease.

Signature:_____ Date:_____
Patient (Parent or Guardian if the patient is a minor)