

Directive to Administrators (Specify which administrators)		WAD (Wednesday) Publication Date	WAD Notice Number	No. of Pages
All Site Administrators		September 22, 2010		1 of 17
WAD Title (Limit to 4-6 Words)			Date Due (if applicable)	Not Applicable After
Resources for Eye Exams and Glasses			N/A	May 27, 2010
From	Title	Signature		Telephone
Kim Coates (Cabinet member or approved by one below)	Supervisor, Student Support Services			242-2615
Inform				
(x) Certificated Staff (x) Classified Staff (x) Parents (x) Post on Bulletin Board Other <u>As Needed</u>				

Administrative Directive

WHO: Students at SFUSD schools needing FREE resources for EYE EXAMS/GLASSES

WHAT: Poor vision in school age children can interfere with coordination, acquisition of skills, achieving developmental milestones, and the ability to learn properly. Early detection and correction of vision problems can alleviate some of these problems with less interference in the child's ability to learn.

WHERE: The following organizations provide free and/or low cost vision care and glasses for SFUSD students who qualify:

- Children's Vision First
- California Vision Project
- LensCrafters *

*NOTE: *Lenscrafters' Hometown Day* is Thursday, October 14th, 2010 (see the attached instructions for referrals and write "Hometown Day" on the One Sight Program referral form when making referrals to the Hometown Day event).

HOW: Eligibility

- 1) Students have either failed the school based vision screening or have demonstrated a need for vision care.
 - 2) Family has economic need and no health insurance that covers eye exams and/or glasses.
- OR
- 3) The family has economic need and has vision insurance but has lost/damaged their glasses and is unable to get new glasses under their current insurance plan.

To Apply

Instructions and applications attached. For questions, please contact:

Nurse of the Day
Student Support Services Department
242-2615

Approved	Cabinet Member Kevin Truitt	Title Associate Superintendent, Student Support Services	Signature
<i>SAN FRANCISCO UNIFIED SCHOOL DISTRICT - WEEKLY ADMINISTRATIVE DIRECTIVE (WAD)</i>			

Children's Vision First

(Formerly JVQ California)

1007 General Kennedy Ave. Suite 210

San Francisco, CA 94129

415.561.7793 phone

415.409.0587 fax

Principals

Students in your schools have an opportunity to participate in the new Children's Vision First vision program, which provides free eye exams and glasses for children who are in need and do not have health insurance.

The Children's Vision First program is designed to be simple and also flexible enough to empower the teachers and health care providers in your schools to identify children who are in need of help and are not being served through existing resources.

Children Who Are Eligible:

- Have failed school based vision screening (grades K: **20/40**, grades 1-12: **20/30**).
- **Have no health insurance** that covers eye exams and glasses.
- Have no economic resources to provide for adequate vision care. (These students are usually eligible for, or are already participating in, the Free or Reduced Lunch Program.)

Making Referrals:

- Referrals can be made by any school employee who can verify the child's eligibility. This is usually the nurse, health clerk or teacher.
- Since not all grades are screened, teachers are especially vital in referring children from those grades not being screened.
- Teachers must make sure that any child suspected of having vision problems is brought to the attention of the school nurse or vision screener for testing.
- Each child failing the vision screening must then be qualified for eligibility for the Children's Vision First program.
- Qualification includes confirmation that the child has no vision insurance and is without economic means for adequate vision care.
- After a child has been qualified, a Children's Vision First Referral Form is filled out and faxed to Children's Vision First.
- Children's Vision First will assign the student to a doctor in his or her neighborhood and mail the doctor's information to the child's parent/guardian. A copy of this letter is faxed to the school contact that referred the child.
- The parent must call their assigned doctor to schedule the appointment.
- The child then receives a free eye exam, and if glasses are required, CVF will manufacture free, quality new glasses and send them to the doctor for dispensing.

Better vision is one of the easiest things we can do to improve a child's potential.
If you have any questions, please call Children's Vision First at 415.561.7793

*Keeping **CHILDREN** in focus*

Children's Vision First

(Formerly JVQ California)

1007 General Kennedy Ave. Suite 210

San Francisco, CA 94129

415.561.7793 phone

415.409.0587 fax

Attention: Teachers

Good News!!!

Students in your school have the opportunity to participate in the Children's Vision First program, which provides **free eye exams and glasses** for our most vulnerable children.

Children are eligible for the Children's Vision First free vision care program if they:

- Have failed the school based vision screening
- Have economic need and **no health insurance of any kind that covers eye exams** and glasses

Making Referrals:

- Make sure the child qualifies: **Has no health insurance and is in economic need.**
- Along with the standard school notification, every child who fails the school vision screening should be sent home with a Children's Vision First "Free Eye Care" letter. This letter is only a tool to help identify children who qualify for our program. **Teachers** should follow up and collect these letters and return them to the school nurse or health clerk. (Unless it is the teacher who will be filling out the Referral Forms)
- Verifying eligibility requirements with the parent/guardian **by phone is equally acceptable.**
- **Once a child is qualified a Children's Vision First Referral Form is filled out** and faxed to Children's Vision First: **415.409.0587** Nurses and vision screeners usually fill out and fax the Children's Vision First Referral Form, however, at some schools it is the teacher who fills out and faxes the Referral Form.
- **Any way you establish that a child is qualified is valid.** (Phone or collect info thru "Free Eye Care" sent home to parents)
- **The Referral Form is all we want or need.**
- **For all grades not being screened**, it is up to the teacher to make sure that any children suspected of having vision problems are brought to the attention of the vision screening team for testing.

What Happens Next?

- When the Referral Form is received by Children's Vision First, a doctor is assigned and a letter with instructions for contacting the doctor is mailed home to the child's parent/guardian.
- A copy of this letter will be faxed to the referrer for record keeping and follow up.
- The **parent must call** their assigned doctor to schedule the appointment for an exam.
- If eyeglasses are prescribed, Children's Vision First manufactures quality new glasses and sends them to the doctor for dispensing. **All doctor services and Children's Vision First eyeglasses are FREE OF CHARGE.**

Follow-up with parents/guardians in the process of verifying insurance and making and keeping doctor appointments is **extremely helpful**. ***Better vision is one of the easiest things we can do to improve a child's potential.***

Nurse/Vision Screener: _____ **Phone:** _____

For further information and/or to obtain the Referral Form, please contact **the Nurse of the Day at 415.242.2615**, or call Children's Vision First at 415.561.7793.

Keeping CHILDREN in focus

Children's Vision First

(Formerly JVQ California)

1007 General Kennedy Ave. Suite 210

San Francisco, CA 94129

415.561.7793 phone

415.409.0587 fax

Guidelines for School Nurses and Health Clerks

Children are eligible for the Children's Vision First free vision care program if they:

- Have failed the school based vision screening
- Have economic need and **no health insurance of any kind that covers eye exams** and glasses

Who can make a Referral?

- Any school employee who can verify the child's eligibility can make referrals to our program. Generally school teachers, health clerks, nurses and secretaries make referrals to Children's Vision First.

How do I make a Referral?

1) **Make sure the child qualifies: Has no health insurance and is in economic need.**

- Along with the standard school notification, every child who fails the school vision screening should be sent home with a Children's Vision First "Free Eye Care" letter. This letter is only a tool to help identify children who qualify for our program. **Teachers** should follow up and collect these letters and return them to the school nurse or health clerk.
- Verifying eligibility requirements with the parent/guardian **by phone is equally acceptable.**
- **Any way you establish that a child is qualified is valid.** (phone or collect info thru "Free Eye Care" sent home to parents) **Once a child is qualified just fill out a Referral Form. The Referral Form is all we want or need.**

2) For all children who qualify, fill out a Children's Vision First Form. You only need to fill in the left side of the form with the child's information and your contact information. (It is extremely important to print very clearly)

3) Fax the completed Children's Vision First Referral Form to **415.409.0587**.

What Happens Next?

- When the Referral Form is received by Children's Vision First, a doctor is assigned and a letter with instructions for contacting the doctor is mailed home to the child's parent/guardian.
- A copy of this letter will be faxed to you for record keeping and follow up.
- The **parent must call** their assigned doctor to schedule the appointment for an exam.
- If eyeglasses are prescribed, Children's Vision First manufactures quality new glasses and sends them to the doctor for dispensing. **All doctor services and Children's Vision First eyeglasses are FREE OF CHARGE.**

Important Reminders:

- Each CVF Referral Form must be filled out and signed by school personnel.
- Only refer eligible children. Doctors are **donating** their time. Therefore, you must refer **only** those students who truly qualify. Only **one** exam per calendar year is allowed.

Replacing Broken or Lost Eyeglasses:

- A second pair or a replacement pair for lost or broken glasses may be purchased for \$35.00.

For further information and/or to obtain the Referral Form, please contact **Nurse of the Day at 415.242.2615**, or call Children's Vision First at 415.561.7793.

Keeping CHILDREN in focus

Ph: (415) 561.7793
 Fax: (415) 409.0587

CHILDREN'S VISION FIRST Referral Form

1007 General Kennedy Ave. Suite 210
 San Francisco, CA 94129

Section I: to be filled out COMPLETELY by school personnel (PLEASE PRINT):

Date: _____ County: _____

School District: _____

Student Name: _____
First Last

Date of Birth: _____ Sex: _____

Grade: _____ Teacher: _____

Parent/Guardian: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Other: (____) _____

Child can get to UC Berkeley School of Optometry Yes No

No Insurance **Emergency MediCal Only** **Other Ins.**

DISPENSE ONLY Insurance Covers Exam but not Glasses

Language spoken in the home:
 English Spanish Cantonese
 Mandarin Vietnamese Portuguese

Visual Acuity
 Screening Info:
 R: _____
 L: _____

School Name: _____ ES MS HS

Contact: _____

Phone: (____) _____ - _____, ext. _____

Fax: (____) _____ - _____

Signed: _____
Screener/School Personnel

Eligibility has been Verified by:

Section 2: to be filled out by Children's Vision First Doctor (PLEASE PRINT):

Student Name: _____ County: _____

Dr. Address: _____

Dr. Phone: (____) _____ - _____ Dr. Fax: (____) _____ - _____

DISPENSE ONLY - NO EXAM **PERSCRIPTION PROVIDED****

Diagnosis (circle all that apply) Exam date: _____

Amblyopia Esotropia Hyperopia Ordering 2nd Pair \$35.00
 Astigmatism Emmetropia Myopia Ordering Frame Only \$12.50*
 Color Blind Glaucoma Strabismus

Other: _____

	Sphere	Cyl	Axis	Prism	Direction	Base Curve	Lens type
R							SV
L							FT
R	Add	Seg Ht	OC Ht	PD			
L				DISTANCE			
				NEAR			
FRAME	COLOR			Eye Size	DBL	VQ SUPPLY	
SPECIAL INSTRUCTIONS:							Send To:
							ENCLOSED

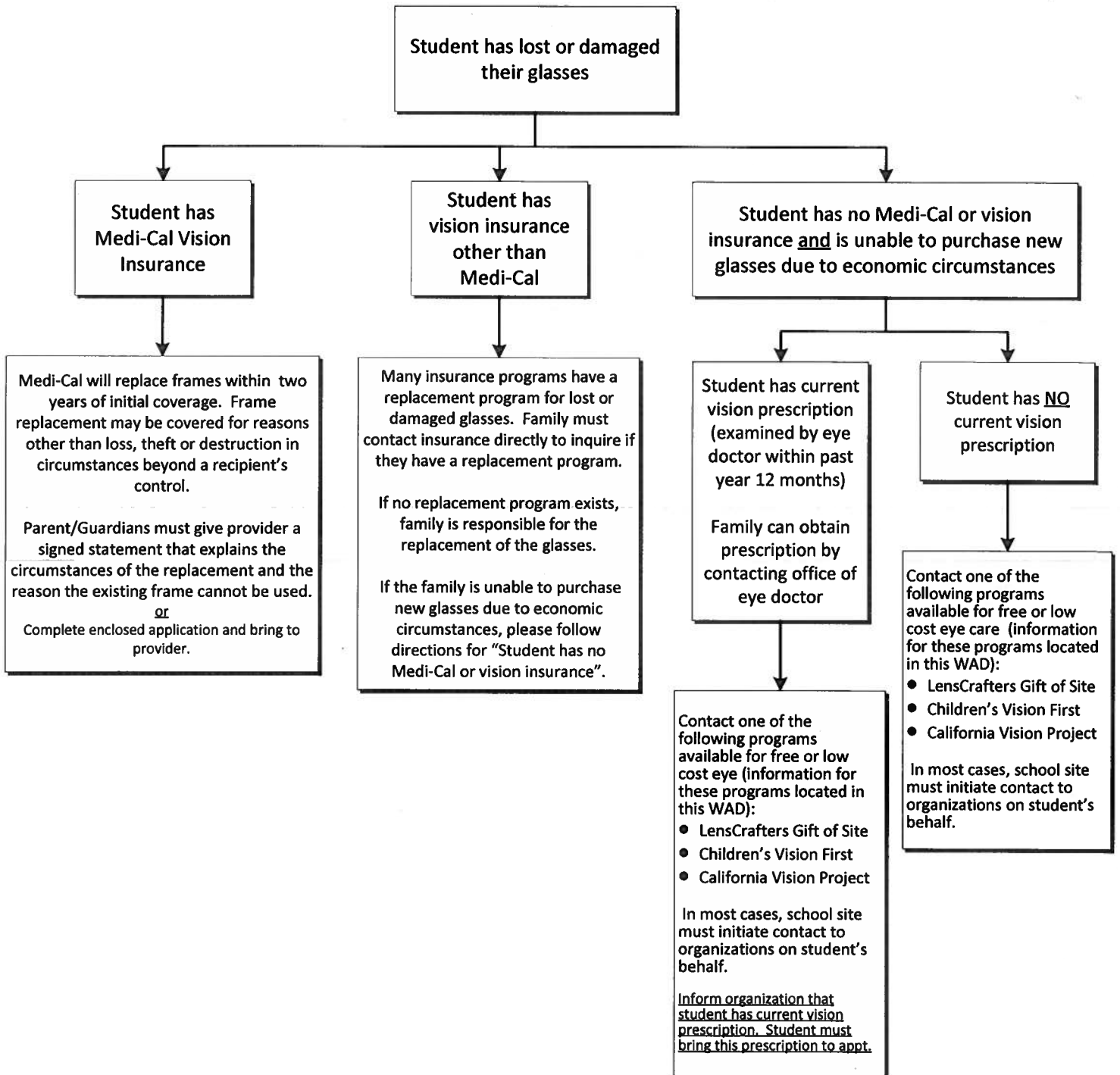
CVF Office Date received: _____ Dr. Info: Parent _____ School _____

Use Only: Faxed to Dr: _____ Faxed to Lab: _____ Dispensed _____

Children's Vision First: **Formerly JVQ California**

* \$12.50 replacement charge does not apply within warranty.
 ** Patient MUST bring current prescription

Procedure for Replacement of Lost or Damaged Glasses for SFUSD Students



Eye Appliances

This section contains general information about eyeglasses and contact lenses and program coverage (California Code of Regulations [CCR], Title 22, Section 51317)

Lost, stolen, broken or significantly damaged eye appliances may not be replaced unless a recipient or recipient's representative supplies the provider with a signed statement. The statement must certify that a loss, breakage, or damage was beyond the recipient's control and must include the circumstances of the loss or destruction and the steps taken to recover the lost item. A recipient's signed statement must be retained in the recipient's file for at least three years.

Date: _____

Dear Doctor _____

The following explains the circumstance of the lost/stolen/broken glasses:

Parent/ Guardian signature

Address _____

California Vision Project (CVP)

2415 K Street, Sacramento, CA 95816

Telephone: (916) 441-3990, Fax: (916) 448-1423

Call toll-free: 1-800-877-5738

GUIDELINES

The California Vision Project is a 501(c)(3) nonprofit organization that provides low-income, working, uninsured, families with free comprehensive eye exams and glasses. Services are provided by volunteer optometrists and may not be available in all areas.

Patient Eligibility and Benefit Information:

Patients are eligible to receive a free comprehensive eye examination and prescription spectacles (if necessary) if the following requirements are met (*NO EXCEPTIONS WILL BE MADE*):

- At least one adult in the household must be employed and working (full-time or part-time)
- The applicant must have no public or private insurance that covers eye exams or glasses
- Applicants must not have had an eye exam in the last 2 years
- Applicants are low income and unable to pay for eye care
- \$10.00 administrative fee (per person) must be included with application

Setting the CVP Patient Appointment:

- Eligible patients will be assigned to a volunteer doctor if there is one available in or near their area.
- Qualified CVP patients receive a letter with their volunteer doctor's name, address and phone number.
- Patients are asked to make an appointment upon receipt of the notification letter. Failure to schedule an appointment within 60 days of the date of the assignment letter will result in disqualification from the Project.
- Volunteer doctors will also receive a letter on a monthly basis, listing patients who have been assigned to them; staff may contact the CVP patient directly to schedule an appointment.
- Patients are warned about not keeping their appointment. They are notified that if they miss their appointment they may be disqualified from the Project.

Processing the Application:

- Applications are processed in the order that they are received and may take from two or up to four months to process.
- The \$10.00 administrative fee is non-refundable except in the case that the patient is determined eligible and the Project does not have a volunteer doctor available in their area.
- Requests to be assigned to a particular volunteer doctor will be considered, but can not be promised.

If a Prescription is Necessary:

- Glasses processed through this Project must be ordered through the doctor's office that the patient is examined through.
- Frames may be limited.
- The patient is limited to only one pair of glasses.
- Glasses must be processed within one month of the patient's examination date.
- Only single vision or bifocal (ST 28) with clear lenses made from CR-39 are covered by this Project.

CALIFORNIA VISION PROJECT (CVP) APPLICATION FORM
 The California Vision Project provides free eye exams to eligible low-income working families.
 Services are donated by volunteer optometrists throughout California.

Eligibility requirements: All eligibility requirements must be met in order to qualify (PLEASE READ)

- At least one adult in the household must be employed (full-time or part-time);
 - The person(s) seeking an eye exam must have no public or private insurance that covers eye exams;
 - Applicants must not have had an eye exam in the last 2 years; and
 - Applicants are low-income and are unable to pay for eye care.
- \$10.00 non-refundable administrative fee (per person) must accompany the application. Check or money orders can be made payable to "The California Vision Foundation"

Please answer all questions below. Verification may be requested.

1. Is anyone in your household currently employed (full-time or part-time)? Yes No
2. What is the total number of people in your household living with you, including yourself? _____
3. What was your household's approximate gross annual income before taxes and deductions? _____
4. How far are you able to travel for your appointment? _____ miles
 Please list any particular cities that you would be able to travel to for your appointment:

List all family members who are applying for a free eye exam:

Name	Date of Birth	Has this person had an eye exam in the last two years?	Does this person have any private or government insurance that covers eye exams?
1. _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. _____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Home address: (Please print)

Address _____
 _____ Apt. # _____
 City _____
 State _____ Zip _____
 Daytime telephone number () _____ - _____

Employer address: (Please print)

Address _____

 City _____
 State _____ Zip _____
 Work telephone number () _____ - _____

Your completed form will be reviewed to determine your eligibility. Eligible patients will be notified by mail and will receive a complete eye exam without cost if a volunteer is available in your area.

Mail this completed application to:
California Vision Foundation
2415 K Street, Sacramento, CA 95816
 If you have any questions please contact Megan Gowin or Michelle Harvey at (800) 877-5738.

FORMULARIO DE SOLICITUD DEL PROYECTO DE LA VISIÓN DE CALIFORNIA (CVP)
 El Proyecto de la Visión de California ofrece exámenes de vista sin cargo a familias de trabajadores de bajos ingresos que cumplen con ciertos requisitos.
 Los servicios son donados por optometristas voluntarios de toda California.

Requisitos que debe cumplir el solicitante: Todos los requisitos de la elegibilidad se deben cumplir para calificar
 (POR FAVOR LEER)

- Al menos un adulto de la casa debe tener trabajo (full-time o part-time);
- La persona o las personas que soliciten el examen de vista no podrán tener seguro público ni privado que cubra el examen de vista;
- El solicitante no deberá haberse realizado un examen de vista en los últimos dos años; y
- Los solicitantes son de bajos ingresos y no pueden pagar la atención oftalmológica.
- Un cargo de \$10.00 administrativo (por persona) tiene que acompañar la aplicación para ser procesada. Cheque o money orders pueden ser escritos a "The California Vision Foundation"

Por favor, responda todas las preguntas. En algunos casos podrá solicitarse verificación.

1. ¿Alguna persona de su hogar trabaja actualmente (full-time o part-time)? Sí No
2. ¿Cuánta gente vive en su casa con usted, incluido usted? _____
3. ¿Cuál fue el ingreso anual bruto aproximado de su hogar antes de impuestos y deducciones? _____
4. ¿Cuán lejos puede viajar para su cita con el oftalmólogo? _____ millas.

Por favor indique algunas de las ciudades específicas a las que podría viajar para su cita con el oftalmólogo:

Indique quiénes son los miembros de la familia que solicitan un examen de vista gratis:

Nombre:	Fecha de nacimiento	¿Esta persona se hizo un análisis de la vista en los últimos dos años?	¿Esta persona tiene seguro privado o del gobierno que cubra exámenes de la vista?
1.	/ /	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
2.	/ /	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
3.	/ /	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
4.	/ /	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No

Dirección del solicitante: (En letra de molde)

Dirección _____
 _____ Nro. de Apto. _____

Ciudad _____

Estado _____ Código postal (Zip) _____

Nro. de teléfono durante el día () _____ - _____

Dirección del empleador: (En letra de molde)

Dirección _____

Ciudad _____

Estado _____ Código postal (Zip) _____

Nro. de teléfono del trabajo () _____ - _____

Se examinará su formulario completo para determinar si usted cumple con los requisitos. Si los cumple, recibirá una notificación por correo y recibirá un examen de vista Integral sin costo si existe un voluntario disponible en su zona.

Envíe este formulario de solicitud completo por correo a:

California Vision Foundation
 2415 K Street, Sacramento, CA 95816

Si tiene alguna pregunta, por favor contacte a Megan Gowin o Michelle Harvey al número (800) 877-5738.

LensCrafters/EyeExam of California

LensCrafters/EyeExam of California has several community assistance programs and has been extremely generous with the students of SFUSD.

HOMETOWN DAY As part of the One Sight Program sponsored Hometown Day's yearly campaign; LensCrafters will be donating free eye exams and prescription glasses to SFUSD students in need of new glasses. This event is for one day only.

When October 14th, 2010. Eye exams and dispensing of glasses occurs on this day only. In some situations, students may need to return to LensCrafters to pick up their glasses at a later date.

Eligibility

- Students have either failed the school based vision screening or have demonstrated a need for vision care.
- Family has economic need and no health insurance that covers eye exams and/or glasses, or
- Family has economic need and has vision insurance but has lost/damaged their glasses and is unable to get new glasses under their current insurance plan.

Procedure

- Contact the Hometown Day Coordinator at one of the LensCrafters/EyeExam of California stores listed below, request an appointment.
- Complete student referral form (complete with school tax ID number) and fax to LensCrafters.
- A patient information form (complete with parent/guardian signature) needs to be completed for all students who will be participating in Hometown Day without their parent/guardian. This form must be with the student at the time of their exam.

Participating Stores

LENSCRAFTERS, MARKET STREET
685 MARKET STREET
SAN FRANCISCO, CA 94105
Ph: (415) 896-0680 Fax: (415) 896-0352

LENSCRAFTERS, STONESTOWN GALLERIA
3251 20TH AVENUE SPACE 219
SAN FRANCISCO, CA 94132
(415) 566-9199

LENSCRAFTERS, PINE & BATTERY
100 BATTERY STREET
SAN FRANCISCO, CA 94111
(415) 399-1473 Fax: (415) 399-1960

LENSCRAFTERS, 280 METRO CENTER
53 COLMA BLVD #F2
COLMA, CA 94014
(650) 992-2700 Fax (650) 992-3215

ONE SIGHT PROGRAM

Each of the LensCrafters/EyeExam of California stores donates 2-3 free eye exams and eyeglasses per month for students in need of eye exams and new glasses. This program is on-going through out the year.

When Most stores set aside one day per week for One Sight appointments. Stores should be contacted directly for schedule

Eligibility

- Students have either failed the school based vision screening or have demonstrated a need for vision care.
- Family has economic need and no health insurance that covers eye exams and/or glasses, or
- Family has economic need and has vision insurance but has lost/damaged their glasses and is unable to get new glasses under their current insurance plan.

Procedure

- Contact the One Sight Coordinator at one of the LensCrafters/EyeExam of California stores listed below, request an appointment.
- Complete student referral form (complete with school tax ID number) and fax to LensCrafters.
- Parent or Guardian of student needs to contact store directly to confirm appointment.

Participating Stores

LENSCRAFTERS, MARKET STREET
685 MARKET STREET
SAN FRANCISCO, CA 94105
Ph: (415) 896-0680 Fax: (415) 896-0352

LENSCRAFTERS, STONESTOWN GALLERIA
3251 20TH AVENUE SPACE 219
SAN FRANCISCO, CA 94132
(415) 566-9199

LENSCRAFTERS, PINE & BATTERY
100 BATTERY STREET
SAN FRANCISCO, CA 94111
(415) 399-1473 Fax: (415) 399-1960

LENSCRAFTERS, 280 METRO CENTER
53 COLMA BLVD #F2
COLMA, CA 94014
(650) 992-2700 Fax (650) 992-3215

LENSCRAFTERS, SERRAMONTE CENTER
5 SERRAMONTE CENTER
DALY CITY, CA 94015
(650) 992-1615 Fax (650) 992-1617

LENSCRAFTERS, THE SHOPS AT TANFORAN
1150 EL CAMINO REAL #265
SAN BRUNO, CA 94066
(650) 583-8693 Fax (650) 583-2097



San Francisco Unified School District
Student Support Services Department
1515 Quintara St.
San Francisco, CA 94116
415/242.2615
Fax: 242.2618
[Http://www.healthiersf.org](http://www.healthiersf.org)

Lenscrafters One Sight Program of California

Attn: One Sight Coordinator

Fax: _____

Dear One Sight Coordinator:

I would like to introduce and refer a student to your One Sight Program. I believe that he/she could greatly benefit from the services that LensCrafters One Sight Program of California has generously offered to the students of San Francisco Unified School District. Unfortunately, some of our students are not insured for vision coverage and the need for eye examinations and glasses is so important for their success in learning. Your service is very much appreciated.

Below you will find pertinent information regarding the student I am referring. Please let me know if you need further information. Thank you on behalf of the children and families of San Francisco.

Name/Title of Referring Staff Member

School Site

Phone Number / *Fax Number*

Date of Referral

Students Name _____	Date of Birth _____
Home Address _____	
Parent/Guardian Name _____	Phone _____
Language Spoken at Home _____	
School _____	School Tax ID _____

OF CALIFORNIA

A LICENSED VISION HEALTH CARE SERVICE PLAN

PATIENT INFORMATION Please Complete at Each Annual Examination (Please Print)

Mr. Master Last Name _____ First Name _____ Initial _____ Sex Male Female Birthdate _____ Age _____
 Mrs. Dr. _____
 Ms. _____

Home Address _____ City _____ State _____ Zip _____

Preferred Telephone Number () _____ Home Work Cell (circle option) _____ Secondary Telephone Number () _____ Home Work Cell (circle option) _____

We use phone calls to remind patients of their appointments. We will use the phone number you provide and the call may be live or prerecorded.

Language Preference: English Spanish Chinese Vietnamese Other _____

Do you need assistance from an interpreter? Yes No

Race: White African American Hispanic Asian/Pacific Islander Other _____

Employer Name _____ Employer Address _____ City _____ State _____

Your Occupation _____ Referred By _____

Will you be using any vision benefits or programs? No Yes If yes, please fill in the information below.

Vision Plan Name _____ Member ID # _____ Insured's Name _____ Patient's Relationship to Insured _____

Would you like to be billed for your services today through the LENS-CRAFTERS account? Yes No

** Note to Technician: If yes, please fill out LENS-CRAFTERS account application.*

We will file an insurance claim for any plan under which we are providers. If you have a question about which plan to use, please ask the technician. Payment is expected at time of treatment.

Are you interested in looking at eyeglasses at LensCrafters today? _____

- Do you have? (please check all that apply)

<input type="checkbox"/> eyestrain	<input type="checkbox"/> pain	<input type="checkbox"/> double vision
<input type="checkbox"/> dry eyes	<input type="checkbox"/> itchy eyes	<input type="checkbox"/> blurred vision with glasses or contacts
<input type="checkbox"/> floaters	<input type="checkbox"/> flashes of light	<input type="checkbox"/> severe or frequent headaches
<input type="checkbox"/> frequent neck and shoulder pain		
- Name of your primary physician: _____
- Age of present glasses: _____ Date of last physical: _____ HMO Member? No Yes
- Have you been examined at EYEXAM of California before? _____ Date of last eye exam: _____
- Have your eyes been dilated before? No Yes Which Office: _____
- Have you had retinal photographs taken before? No Yes When: _____
- Do you or any blood relatives (grandparents, parents, brothers, sisters, children) have? (please check all that apply)

	Self	Blood Relative		Self	Blood Relative
retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
cataracts	<input type="checkbox"/>	<input type="checkbox"/>	thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	lung disease	<input type="checkbox"/>	<input type="checkbox"/>
high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	<input type="checkbox"/>
- Are you pregnant? (if applicable) No Yes
- Are you being treated for any medical condition? No Yes Please List _____
- Are you taking any medications? No Yes Please List _____
- Are you allergic to any medication including eye drops? No Yes Please List _____
- Do you have or have you ever had any eye disease, injury or surgery? No Yes
If yes please explain: _____

PATIENT VERIFICATION

The patient history information that I have provided above is accurate and complete to the best of my knowledge.

Signature (If under 18 years of age, parent signature required) _____ Date _____