

Keith Tokuhara, M.D.

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760.340.4700

Welcome to the Ophthalmology practice of Dr. Keith G. Tokuhara located on the Eisenhower Medical Center campus where we will always strive to exceed your expectations. Your appointment has been scheduled on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You should expect your first visit to take up to 2 hours. This time may vary according to your individual needs. Your eyes will be dilated, so bring your sunglasses. You may prefer that someone else drives you home after the exam. We try to stay on schedule but may run behind if patients ahead of you need more time. Dr. Tokuhara will give you the same attention and care during your examination.

We have enclosed PATIENT INFORMATION forms. Please complete these and return them in the yellow envelope at least one week before your appointment, so we can prepare your electronic medical chart. For reference, you may keep this introduction letter to review before your appointment.

If you have medical insurance, please bring in your insurance card(s). The receptionist will make a copy of your card(s) on arrival. Most private insurances, including Medicare, do not cover the entire cost of vision screening exams.

We accept Medicare, and Dr. Tokuhara is a Medicare provider. Desert Vision Center allows Medicare to assign the payment benefit directly to you. This is called, “Medicare non-assignment.” In other words, Desert Vision Center will collect the payment from you at the time of service at your office visit. Then, the Desert Vision Center billing department will send a claim of your visit to Medicare. Once processed, Medicare will then mail the benefit check directly to you. The charges for your first visit may vary depending on the services rendered. Services differ for individual eye problems.

Please bring all current glasses you are wearing. You do not need to bring the glasses you no longer use or wear. If you wear contact lenses, please wear them to the office. Please bring the contact lenses manufacturer’s box. Our office does not provide contact lens services. If you need contact lens services or fitting, we will give you a referral.

We hope this brief introduction to our office has answered some of your initial questions. We will be happy to discuss any other questions you may have when you are in the office. In the meantime, please visit our website at www.desertvisioncenter.com. We look forward to meeting you.

Sincerely,

Dr. Tokuhara and the Desert Vision Center Team

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_ Age­­­\_\_\_\_ Sex\_\_\_\_ Marital Status \_\_\_\_\_

Local Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Local Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse or Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse or Parent’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Family Physician/ Primary Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:

Family Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Friend\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person responsible for payment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Today:  Cash Check Visa/Mastercard

INSURANCE INFORMATION: (check all that apply)

Medicare Only Medicare/MediCal Medicare with Supplemental

 Medicare Advantage Medicare is Primary Medicare is Secondary

Private Insurance No Insurance Coverage

Medicare #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare Supplement Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare Supplement I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policyholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of any medical information necessary to process my insurance claim as requested by my insurance company. I understand that full payment is due at the time of service, unless Dr. Tokuhara has a contractual agreement with my insurance. I assign all payments to Desert Vision Center for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred language: English Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race/Ethnicity:

 American Indian/Alaska Native  African American  Hawaiian/Pacific Islander

 Hispanic/Latino Caucasian  Asian  Other \_\_\_\_\_\_\_\_\_  Decline to Answer

Smoking Status: Current Smoker  Former Smoker  Never Smoked

Alcohol use:  Yes  No Alcohol Amount per day: \_\_\_\_\_\_\_\_\_\_

Flu Shot:  Yes  No Pneumonia Vaccination:  Yes  No

Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cross Streets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List your Drug Allergies: Reaction:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List your medications and dosage:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:** Check all that apply

 Asthma  Hepatitis  HIV/AIDS  Seizure Disorder  Tuberculosis

 Herpes  Lupus  Stroke  High Blood Pressure  Migraine

 Thyroid  Heart Disease  High Cholesterol  Thyroid  Rheumatoid Arthritis

 Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: Blood Sugar Today \_\_\_\_\_\_\_\_\_ Last A1c \_\_\_\_\_ Diabetic Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History and Relationship to you:** Mother, Father, Sibling, or Child only

**Condition**  **Relationship to you**

 Blindness ……………………………………\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cancer ………………………………………..\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cataract ……………………………………..\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diabetes …………………………………….\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Glaucoma …………………………………..\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Heart Disease …………………………….\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lazy Eye …………………………………….\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Macular Degeneration………………..\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Retina Disease ………………………….\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Thyroid Disease …………………………\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:** List surgeries and approximate dates including eye surgeries and lasers.

When was your last eye exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you wear Contact Lenses?  Yes  No

 Do you have prism in your glasses?  Yes  No

**Eye Conditions:** Past and Present, Please check ALL that apply

 Blindness/Low Vision  Glaucoma  Eye Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Retina Disease  Macular Degeneration  Cataracts

  Lazy Eye/Turned Eye  Color Blindness  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Visual Symptoms:** Please check ALL that apply

 Blurred distance vision  Eye strain  Headache  Glare sensitivity

 Blurred near vision  Double Vision  Temporary loss of vision

 Flashing Light  Floaters  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Standardized Patient Evaluation of Eye Dryness (SPEED)**

*Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.*

**1**. Report the type of **SYMPTOMS** you experience and when they occur:

 **At this visit** **Within past 72hour** **Within past 3 month**

 a. Dryness,Grittiness  YES  NO  YES  NO  YES  NO

 b. Soreness or Irritation  YES  NO  YES  NO  YES  NO

 c. Burning or Watering  YES  NO  YES  NO  YES  NO

 d. Eye Fatigue  YES  NO  YES  NO  YES  NO

**2**. Report the **FREQUENCY** of your symptoms using the rating list below:

 a. Dryness,Grittiness  Never  Sometimes  Often Constant

 b. Soreness or Irritation  Never  Sometimes  Often Constant

 c. Burning or Watering  Never  Sometimes  Often Constant

 d. Eye Fatigue  Never  Sometimes  Often Constant

**3**. Report the **SEVERITY** of your symptoms using the rating list below:

 a. Dryness,Grittiness  None  Tolerable  Uncomfortable  Bother  Intolerable

 b. Soreness or Irritation  None  Tolerable  Uncomfortable  Bother  Intolerable

 c. Burning or Watering  None  Tolerable  Uncomfortable  Bother  Intolerable

 d. Eye Fatigue  None  Tolerable  Uncomfortable  Bother  Intolerable

 TOTAL SPEED SCORE (office use): \_\_\_\_\_\_\_\_\_

**4**. Do you use eye drops for lubrication?  YES  NO

If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_

What type/brand?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5**. How would you rate your personality?

  Easy Going  Middle of the Road  Perfectionist

**6**. Rate your Overall Dry Eye Severity of a day-to-day basis using a scale of 1-10: \_\_\_\_\_\_\_\_\_

**7**. How many dry eye medication drops and treatments are you currently using?

  None

1-3

* 4-6
* 7 or More

**8**. Allergy Symptoms:

 Itchy Eyes  Red Eyes  Watery Eyes  Swollen Eyes/Eyelids

  Congestion  Runny Nose Itchy Skin  Asthma Dark Circles under Eyes

**9**. Sjogren's Symptoms

A. How long have you been treated for dry eye disease? \_\_\_\_\_\_\_\_\_

B. Do you experience any of the following signs/symptoms?

  Dry Mouth  Fatigue/Body Aches  GI Distress

  Muscle Weakness or Numbness of arms/legs  Inability to Concentrate

C. Have you or a family member ever been diagnosed with an autoimmune disease such as Lupus, Rheumatoid Arthritis, Sjogrens' or other associated autoimmune disease?

 YES  NO

**10.** Vision Goals:

 What would you like to improve with your eye condition?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Notifications**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT**

 Insurance Companies will only pay for services that they determine to be covered benefits. If your insurance determines a particular service is not covered under their program, they will deny payment for that service and you will be responsible for the payment.

**THE REFRACTION PORTION OF YOUR EYE EXAM IS NOT COVERED BY INSURANCE**

 I have been notified that my insurance may not cover my eye exam or the refraction portion of my eye exam. I agree to be personally responsible for the payment of that service.

**DILATED PUPIL EXAM**

 Your eyes maybe dilated during your exam. This may cause temporary blurred near vision, glare, light sensitivity, and in some cases, difficulty focusing at distance. You should wear dark sunglasses and use the precautions driving and walking. Dilation may last two to six hours. If you have a retinal, macular, or diabetic diagnosis, your dilation maybe stronger than you should arrange for a driver on your first visit to our office. Thank you for completing your Health History Questionnaire.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_