Dear

Please allow us to welcome you to our practice. Our first priority is to provide you with the best care possible.

Enclosed is your patient information sheet and medical history questionnaire. Please complete them and bring them with you on the date of your appointment.

Please also bring with you a list of current medications, your health insurance card(s) and your glasses.

If you should need to reschedule your appointment for any reason, please give us at least 24 hours notice.

We look forward to serving you.

Paul L. Treger, MD
Glenn B. Cook, Md, PhD
Randall Conrad, OD
Tara Brown, MD
PAUL TREGER, M.D.                        GLENN B. COOK, M.D., PhD.
RANDALL CONRAD, O.D.                 TARA BROWN, M.D.

PLEASE REVIEW FOR ACCURACY AND COMPLETE WHERE APPROPRIATE

PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address One:</td>
<td>Social Security #:</td>
</tr>
<tr>
<td>Address Two:</td>
<td>Sex: F</td>
</tr>
<tr>
<td>City:</td>
<td>Usual Provider: GLENN COOK</td>
</tr>
<tr>
<td>State:</td>
<td>Zip:</td>
</tr>
<tr>
<td>Home Phone#:</td>
<td>Emergency Contact:</td>
</tr>
<tr>
<td>Work Phone#:</td>
<td>Emergency Phone#:</td>
</tr>
<tr>
<td>Cell Phone#:</td>
<td>Emergency Relationship:</td>
</tr>
</tbody>
</table>

GUARANTOR INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
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<tbody>
<tr>
<td>Address One:</td>
<td>Social Security#:</td>
</tr>
<tr>
<td>Address Two:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>Employer:</td>
</tr>
<tr>
<td>State:</td>
<td>Zip:</td>
</tr>
<tr>
<td>Home Phone#:</td>
<td>Employer Address:</td>
</tr>
<tr>
<td>Work Phone#:</td>
<td>Employer City:</td>
</tr>
<tr>
<td>Cell Phone#:</td>
<td>Employer State: Zip:</td>
</tr>
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</table>

INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Primary Insurance:</th>
<th>Secondary Insurance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate#:</td>
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</tr>
<tr>
<td>Group Number:</td>
<td>Group Number:</td>
</tr>
<tr>
<td>Group Name:</td>
<td>Group Name:</td>
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<td>Copay:</td>
<td>Copay:</td>
</tr>
<tr>
<td>Subscriber Name:</td>
<td>Subscriber Name:</td>
</tr>
</tbody>
</table>

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, La Mesa Eye & Paul Treger when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, La Mesa Eye & Paul Treger to release any information necessary for my course of treatment.

______________________________  ____________________
Signed (patient or parent if minor)  Date
PAUL L. TREGER, M.D., F.A.C.S  
GLENN B. COOK, MD, PhD  

Medical History Form  
TODAY'S DATE: ____________________

PATIENT NAME ____________________

FAMILY (PRIMARY) PHYSICIAN __________ PHONE #(____) __________

DO YOU HAVE ANY CURRENT MEDICAL PROBLEMS? PLEASE EXPLAIN

________________________________________________________________________

CURRENT MEDICATIONS                  CURRENT EYE MEDICATIONS

________________________________________________________________________

________________________________________________________________________

ALLERGIES      YES   NO

PLEASE LIST ___________________________________________________________

MEDICAL SYSTEM REVIEW  
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

( ) HIGH BLOOD PRESSURE   ( ) CANCER OF ANY KIND
( ) DIABETES             ( ) KIDNEY DISORDER
( ) BREATHING PROBLEMS   ( ) THYROID DISEASE
( ) MIGRAINE HEADACHES   ( ) STROKE
( ) HEART PROBLEMS       ( ) SKIN DISORDER
( ) ANEMIA               ( ) INTESTINAL DISORDER
PRIOR SURGERIES (INCLUDING EYE SURGERY)

___________________________________________  __________________________

FAMILY HISTORY:    FAMILY MEMBER:

(  ) DIABETES    __________________________
(  ) HEART DISEASE   __________________________
(  ) HIGH BLOOD PRESSURE __________________________
(  ) CANCER    __________________________
(  ) CATARACTS  __________________________
(  ) GLAUCOMA    __________________________
(  ) RETINAL DISEASE  __________________________
(  ) BLINDNESS    __________________________

SOCIAL HISTORY

(  ) SMOKER    PACKS PER DAY ___________
(  ) ALCOHOL USE   AMOUNT PER DAY__________

OCCUPATION________________________________________________

EYE HISTORY:

(  ) CONTACT LENSES IF YES WHAT TYPE? ________________

PREVIOUS EYE SURGERY: (PLEASE PROVIDE DATES)

CATARACT  R_______   L_______
LASER    R_______   L_______   WHAT TYPE _________
GLAUCOMA R_______   L_______
OTHER   R_______    L_______   WHAT TYPE _________
EYE SYSTEM REVIEW:

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS:

( ) COMPLETE OR PARTIAL LOSS OF VISION
( ) CATARACTS
( ) GLAUCOMA
( ) MACULAR DEGENERATION
( ) EYE DISEASE FROM DIABETES
( ) IRITIS OR INFLAMMATION INSIDE THE EYE
( ) DRY EYES
( ) EYELID INFECTIONS (BLEPHARITIS)
( ) LAZY (AMBYLOPIC) EYE
( ) CROSSED OR DEVIATED EYES
( ) DOUBLE VISION
( ) GROWTHS ON EYELIDS OR EYES
( ) EYE INJURY
( ) CONSTANT TEARING OF EYE(S)

WHAT IS THE PURPOSE OF TODAY’S EXAM?
TO OUR PATIENTS

Refraction

The portion of an eye exam known as a “Refraction” is not covered by most insurance companies (including Medicare). This part of the examination is done to determine your current need for glasses.

The charge for the “Refraction” is $35.00. If you do not wish this optional portion of the examination to be performed, please inform the technician at the beginning of the exam.

If you wish to have this portion of the exam completed, and it is known that your insurance will not cover it, you will be asked to pay the $35.00 charge upon completion of your examination.

No Show/ Canceled Appointment Policy

If you fail to give our office 24 hour notice of cancellation of your appointment we reserve the right to charge you $25.00 for your appointment time.

Returned Check Fee

$25.00 Service charge

Collection Services

$50.00 Administration Fee will be added to the account

Form Fee

$10.00 Administration Fee for forms required to be completed by Physician

Insurance Patients (PPO or HMO)

You agree to assume full financial responsibility for all medical services provided to you in the event it is determined by the insurance carrier that you were ineligible for benefits at the time of service, did not provide correct insurance information, or the service was not covered.

____________________________________                             ____________________
Signature                       Date

Print Name