

PATIENT INFORMATION

Thank you for choosing our office for your vision care. If you have any questions or concerns, please ask.

Name: _____ M F DOB ____/____/____ Age ____ Last Eye Exam _____

Address: _____ City: _____ State: _____ Zip: _____

Phone H: _____ W: _____ C: _____ e-mail _____

Referred by: _____ How did your hear about our office: _____

Vision Insurance: _____ Vision Insurance ID: _____ Physician: _____

HEALTH HISTORY

Reason(s) for Today's Visit: _____

Do You, or Any Immediate Family Member's Have:

- | Self | Self | Family | Self | Self |
|--|--------------------------|--|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Refractive Surgery |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Retinal Disease | <input type="checkbox"/> Drug Sensitivities | <input type="checkbox"/> Eye Infection |
| <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Dry Eyes | |
| <input type="checkbox"/> Unusual Headaches | <input type="checkbox"/> | <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Color Vision Problems | |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> Strabismus (eye turn) | <input type="checkbox"/> Other _____ | |

Current Medications _____**LIFESTYLE**

Occupation: _____ Computer Use: _____ Hrs/Day _____ Hrs/Week Outdoors: _____

Recreation, Hobbies, Sports _____

- (Check box if Yes) Have prescription sunglasses? With 100% UV protection? With polarized lenses?
 Wear contact lenses? Type _____ Solutions _____ Not wearing lenses now, but have tried.
 Daily Wear (removed nightly) Hours/Day _____ Continuous Wear (slept in) Interested in trying contact lenses.

If you wear bifocal glasses, are you bothered by the lines or head tilting? Yes NoHave more than one pair of prescription glasses? Yes No Interested in thinner, lighter lenses? Yes No

We may need to instill eye drops to dilate the pupils in order to more thoroughly examine the eyes. This allows a more comprehensive evaluation of both ocular and systemic health. You will experience blurred near vision, light sensitivity and mild decrease in distance vision for about four to six hours after dilation.

-
- I Accept Dilation
-
- I Decline Dilation
-
- I Prefer to Reschedule Dilation

Signature _____ Date _____

OVER

PATIENT ACKNOWLEDGEMENT FORM

I understand Eye Etc.’s legal obligation to keep identifiable health information private and confidential. I understand that Eye Etc. may use and disclose the patient’s personal health information for treatment, payment and health care operations.

Eye Etc. has a detailed document called the “Notice of Privacy Practices”. It contains more information about the policies protecting the patient’s privacy. I understand that I have the right to read the “Notice” before signing this Acknowledgement.

Within this “Notice of Privacy Practices” is contained a complete description of my privacy and confidentiality rights. These rights include, but are not limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law and requesting that communications to me regarding my care be by specified methods.

Eye Etc. has established procedures which helps them meet their obligation to patients. These procedures may include other signature requirements and authorizations, reasonable time frames for requesting information, charges for copies and non-routine information needs, etc. I will assist Eye Etc. by following these procedures if I choose to exercise my rights described in the “Notice of Privacy Practices.”

My signature below indicates that I have been given the chance to review a current copy of Eye Etc.’s “Notice of Privacy Practices” and I am consenting to Eye Etc. to use and disclose my protected health information to carry out treatment, payment and health care operations.

I may revoke this authorization in writing except to the extent that the practice has already made disclosures in reliance upon my prior authorization. A photocopy of this shall be considered as effective and valid as the original.

Signature of Patient or Responsible Party: _____ Date: _____

It is the patient’s responsibility to know who is the Provider of their Vision Care Benefits.

Once authorized, we can explain your benefits and costs to you.

Your Insurance/Benefits card or ID must be given to us BEFORE your time of service.

Patients are responsible for fees not covered by their insurance.

If no Benefits or Insurance are made known to us before services are provided, patients are responsible for all fees on services and materials. No Refunds.

Your appointment time is reserved exclusively for you. If you fail to show for your appointment without canceling 24 hours in advance, you will be subject to a no-show fee.

Please sign that you have read and agree to this office policy.

Patient or Responsible Party: _____ Date: _____