Overland**Optical**
FamilyEyeCare

WELCOME TO OUR OFFICE

Patient Information

Today's Date: _____/_____/_____

First Name: _____ MI: _____

Last Name: _____

DOB: _____/_____/_____ Gender: M / F / Other

Address: _____

City: _____ State: ____ Zip: _____

Preferred Phone #: _____-_____-_____ home / cell / work

Alternate Phone #: _____-_____-_____ home / cell / work

Email: _____

Social Security #: _____-_____-_____

Marital Status: _____

Employer: _____

Occupation: _____

Parent / Guardian: _____

Please, circle how you would prefer to receive reminders for appointments, eyeglasses pick up and special events.

Email Text Phone Call/Postcard

Lifestyle Questions

Are you planning on getting a contact lens evaluation today? (Additional fees apply)

☐ Yes ☐ No ☐ Maybe

Do you…? (check all that apply)

☐ ...wear prescription glasses?
☐ …have ultraviolet protection sun wear?
☐ …have "back up" prescription eyewear?
☐ …wear contact lenses?
If so, what kind? _____
Solution Used: _____
☐ …use a computer, smartphone, tablet?
If so, _____Total hrs/day
☐ …have children?

How did you find out about our office?

Where have you seen us? (Check all that apply)

☐ Insurance List ☐ Google
☐ Facebook / Social Media ☐ Our Website
☐ Another Patient: _____
☐ Another Doctor: _____
☐ Other: _____

Patient Eye History

Date of Last Eye Exam: _____

Previous Eye Doctor: _____

Have you ever experienced the following?

(Check all that apply)	**Currently**	**In the Past**
Blurry Distance Vison	☐	☐
Blurry Near Vison	☐	☐
Eyestrain / Eye Fatigue	☐	☐
Headaches / Migraines	☐	☐
Vision Loss	☐	☐
Double Vision	☐	☐
Eye Injury	☐	☐
Eye Allergies	☐	☐
Eye Infections	☐	☐
Eye Pain	☐	☐
Dry / Burning Eyes	☐	☐
Flashes of light	☐	☐
Floaters/Spots	☐	☐
Red Eyes	☐	☐
Itchy Eyes	☐	☐
Light Sensitivity	☐	☐
Watery Eyes	☐	☐

Contact Lens Agreement

I understand that a contact lens exam consists of 2 parts: the routine eye exam, and the contact lens evaluation. The contact lens evaluation is not covered by most insurances and is payable on the date of service. The contact lens evaluation can range from $45-$150 depending on complexity and lens type.

_____ _____
Patient Signature Date

Medical History

Primary Care Physician _____

PCP Phone # _____-_____-_____

Date of Last Exam _____

Please indicate if **you and/or a family member** have ever had any of the following:

Blindness	Yes	No	Family
Cataracts	Yes	No	Family
Any Type of Eye Surgery	Yes	No	Family
Glaucoma	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Problems	Yes	No	Family
Lazy Eye / Amblyopia	Yes	No	Family
Eye Turn / Crossed Eye	Yes	No	Family
Other Eye Disease	Yes	No	Family
Heart / Vascular Disease	Yes	No	Family
Stroke	Yes	No	Family
High Blood Pressure	Yes	No	Family
Unexplained weight loss	Yes	No	Family
Diabetes	Yes	No	Family
Thyroid Dysfunction	Yes	No	Family
Stomach Condition	Yes	No	Family
Liver Condition	Yes	No	Family
Sexually Transmitted Disease	Yes	No	Family
Kidney Disease	Yes	No	Family
Ear, nose, throat condition	Yes	No	Family
Blood / Lymph Disorder	Yes	No	Family
HIV / Aids	Yes	No	Family
Lupus	Yes	No	Family
Seasonal Allergies	Yes	No	Family
Skin Conditions	Yes	No	Family
Arthritis / Rheumatoid Arthritis	Yes	No	Family
Neurological Condition	Yes	No	Family
Psychiatric Disorder	Yes	No	Family
Lung Disease	Yes	No	Family
Cancer	Yes	No	Family
Are you pregnant?	Yes	No	
Are you nursing?	Yes	No	
Any surgeries or major injuries?	Yes	No	

If so, please describe _____

_____

Current Medications: _____

_____

Allergies to medicines?	Yes	No

If so, what medication(s)? _____

_____

Tobacco:	Never	Current	Former

Privacy Practices for Health Information

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Overland Optical Family Eye Care's (OOFEC) statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize OOFEC to release any medical information that may be necessary for medical benefit or to obtain payment for services. This includes vision plans or medical insurances.

CONSENT FOR TREATMENT: I hereby authorize OOFEC to administer diagnostic and medical procedures as necessary for proper health care.

_____ _____

Patient Signature Date

Financial Responsibility

I authorize payment directly to OOFEC for all services rendered to me by OOFEC or any of its authorized associates for the payment of any and all charges incurred as a result of this and/or any subsequent office visit(s). I have provided OOFEC my current insurance information and any referral I may need. I understand that any co-payments or self-pay amounts are due at the time of service. If there are charges not paid or covered by my insurance company, I understand I am financially financial responsible for any amount not covered. I agree that if I default on payment and turned over for collections and/or legal action, I am responsible for any fee(s) incurred, up to and including finance charges, late charges and a 25% attorney fee.

_____ _____

Patient Signature Date

Authorization of Release of PHI

I, _____would like the following persons to have access to my private health information (PHI) upon their request:

☐ No one other than the patient allowed access

☐ Family members and/or other individuals listed: (please include name and relationship to patient)

_____

_____

_____ _____

Patient Signature Date

THANK YOU!