Look Optical

☐ North Denver	☐ Aurora	☐ Montbello/Green Valley	☐ Westminster
5790 W 44th Ave Denver, CO 80212 *303-421-4422*	3130 S Parker Rd Aurora, CO 80014 *303-752-2662*	4804 N Chambers Rd Denver, CO 80239 *303-576-6655*	8737 Sheridan Blvd Westminster, CO 80003 *303-412-6570*

Patient Information (Please Print)

☐ Check here if information is the same

First Name	Last Name		Date		
Address			Occupation		
City	State	Zip Code	Date of Birth	Age	☐ Male ☐ Female
Home Phone Number		Cell Phone Number			
Email Address		Approximate date of last eye examination			

What brings you to our office today?

Please check all that apply.

☐ Routine Eye Exam ☐ Want Glasses
☐ Want Contact Lenses ☐ Other: _____

☐ Double Vision ☐ Tearing ☐ Flashes/Floaters
☐ Eye Infection ☐ Burning Eye(s) ☐ Headaches
☐ Eye Strain ☐ Red Eye ☐ Glare

Do you currently?

Please check all that apply.

Wear Glasses? ☐ Yes ☐ No

☐ Distance ☐ Readers ☐ Lined Multi-focal ☐ Progressive

Wear Contacts? ☐ Yes ☐ No Brand _____

☐ Daily Disposables ☐ Toric
☐ Weekly Disposables ☐ Hard or Gas Permeable
☐ Monthly Disposables ☐ Bifocal or Mono Vision

Eye Health: Do you now or have you ever had?

Please check all that apply.

☐ Eye Injury ☐ Lazy eye (amblyopia)
☐ Eye surgery or LASIK ☐ Strabismus (eye turn)
☐ Cataracts ☐ Vision Therapy
☐ Macular Degeneration ☐ Keratoconus
☐ Glaucoma ☐ Other: _____

Have you been diagnosed with ___?

Please check all that apply.

☐ Diabetes ☐ Heart disease
☐ High blood pressure ☐ Thyroid disease
☐ High Cholesterol ☐ Allergies / Hay fever
☐ Arthritis ☐ Cancer
☐ Pregnant/Nursing ☐ HIV/AIDS
☐ Other: _____

Are you allergic to any medications?
☐ No ☐ Yes If yes, please list: _____

Please list all medications you are taking: _____

Please summarize your family Medical History: _____

Do you smoke tobacco products?
☐ No ☐ Yes If yes, how long: _____

Retinal Exam: Dilation or Optos®

Dilation: Drops are used to enlarge the pupil, allowing the doctor to see a more complete view of the retina. The drops will cause light sensitivity and blurred vision, especially up-close, for approximately four to six hours. This will add approximately 30 minutes to your exam.

Optos: Optos is a fast, painless, and comfortable digital imaging of the retina. The Optos allows your doctor to confirm your retinal health, or discover signs of abnormalities. It provides a permanent record of your retina that can be compared and/or reviewed at next year's exam. Drops are not required in most cases. This is the Doctors' preferred method and a copy of the image can be made available to you.

☐ **Dilation** **OR** ☐ **Optos**

Optos is an additional $39.00

One or the other is recommended every year.

Look Optical

☐ **North Denver**
5790 W 44th Ave
Denver, CO 80212
303-421-4422

☐ **Aurora**
3130 S Parker Rd
Aurora, CO 80014
303-752-2662

☐ **Montbello/Green Valley**
4804 N Chambers Rd
Denver, CO 80239
303-576-6655

☐ **Westminster**
8737 Sheridan Blvd
Westminster, CO 80003
303-412-6570

Insurance Information

Vision Insurance

Vision Insurance: ☐ Yes ☐ No Provider: _____

Insured's Name: _____ Insured's Date of Birth: _____ Relationship: _____

Insured's Employer: _____ Insured's Member ID#: _____

Medical Insurance

Medical Insurance: _____

Insured's Name: _____ Insured's Date of Birth: _____ Relationship: _____

Insured's Member ID#: _____ Insured's Group Number: _____

Insured's Employer: _____

Acknowledgments

Patient Notification – Consent to Treatment

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any of the following concerns: family history, current medical disease and/or conditions, chief complaint or pre-test findings the Doctor may find it necessary to bill your exam medically as well as order additional tests. You will be notified during the course of the exam if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and you are subjected to their specific co-pays, deductibles, and co-insurance which will be due at the time of service. In the event you want a routine examination for your eyeglasses or contact lens prescription, you understand it is your responsibility to immediately inform the Doctor so that they can refer you to the appropriate Specialist for any medical concerns.

Financial Acknowledgment

I hereby authorize any person/institution rendering care to furnish all facts concerning this claim. I authorize payment for my vision benefits and/medical benefits to go directly to Look Optical. I authorize the practice to deposit checks received on my account made out to me for services rendered. I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. Authorization obtained at the time of service does not guarantee payment and any denied services will be balanced and billed to the patient.

Patients with insurance must present their information to us prior to any service(s)/purchase(s). We will not bill the insurance after the service(s)/product(s) are already performed, therefore there will be no refund! You may send the receipt to your insurance company and try to get reimbursed yourself. In the case that a return is needed, there will only be store credit. No monetary refund will be given.

HIPAA Compliance and Release of Information

Look Optical is subject to State and Federal regulations. The practice and/or its doctor may disclose all or any part of the patient's record for this service to any person or corporation which is or may be liable under a contract to the Optometrist, or to a family member or employer of the patient for all or part of the provider's charges, including, but not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, referring professionals, and all authorized auditors as specified in the Insurance Carrier Guidelines and referring professionals. The practice follows HIPAA guidelines. A detailed report of the practice's Notice of Privacy Practices is available upon request.

Consent of Acknowledgments

I have read the "Consent to Treatment", "Financial Acknowledgment", and "HIPAA Compliance and Release of Information" as the Patient, the Patient authorized representative, or general Agent for the purpose of signing this document, hereby accept its terms.

Patient Name (Please Print): _____

Patient/Guardian Signature: _____

Date: _____