Patient's Name:_____ Date of Birth:_____/_____/_____

Street Address:_____ City:_____

State:_____ Zip Code:_____ Cell:_____ Home Phone:_____

Social Security Number:_____ Email:_____

Emergency Contact Name:_____ Tel:_____

Please list names and contact information of all individuals whom we may share your health and related financial information with:_____

_____

_____

Insurance Information:	PRIMARY Vision Insurance	PRIMARY Medical Insurance
Insurance Company		
Member ID		
Subscriber's Full Name		
Subscriber's DOB		
Subscriber's SS#		
Relationship to Patient		

Please list all additional insurance plans:_____

Financial Responsibility:
All professional fees are due on the day of the exam. Our office makes every effort to verify co-pays and other patient responsibilities on the day of the exam. However, the exact amount of the patient's responsibility can only be determined after the claim has been filed. If this amount differs from the amount charged on the exam date, the patient will be billed for the remaining balance or refunded in case of an overpayment. Patient is also responsible for payment of services denied or otherwise not paid by his/her insurance company in a timely manner. By signing at the bottom of this page you agree to these terms and you authorize payment of medical benefits to our providers for the services they rendered.

After-hour Emergencies:
Our doctors of optometry are contracted to work during regular business hours. We make every effort to accommodate every patient's needs. In the case of an after-hour emergency we ask that you call 911 or visit the closest emergency room.

Privacy Policy:
Protecting your privacy is our top priority. Current copies of our "Notice of Privacy Practices" are always available for your review at our front desk. By signing this page you certify that you have read and accepted our "Notice of Privacy Practices" and you agree to be treated at our office under those terms. You also agree to keep us updated with any changes in information provided on this page.

_____ _____/_____/_____

Signature of Patient (Parent/Guardian if patient is under 18) Date

Patient's Name:_____ Date of Birth:_____/_____/_____

Please list all previous eye surgery, trauma, and diagnosis with date: (Or attach list)

_____

When was your last eye exam?_____/_____/_____Where?_____

Do you currently wear contact lenses? ☐Yes ☐No If YES, what type? ☐Soft ☐RGP ☐Other:_____

Who is your primary care physician?_____

Please list all medications that you take, including eye drops and over-the-counters: (Or attach list)

_____

Please list all medications that you are allergic to: (Or attach list)

_____

Please mark all that apply to you:

Eyes:	☐None	☐Seeing Flashes	☐Seeing Floaters	☐Visual Changes	☐Other:_____	
General:	☐None	☐Cancer	☐Fever			
Genitourinary:	☐None	☐Kidney Disease	☐Prostate Problem			
Gastrointestinal:	☐None	☐Liver Disease	☐Colitis			
Psychiatric:	☐None	☐Anxiety	☐Panic Attacks			
Endocrine:	☐None	☐Thyroid Disorder	☐Diabetes History			
ENT:	☐None	☐Sinus Problem	☐Hearing Loss			
Allergic, immunologic:	☐None	☐Seasonal Allergy	☐Lupus			
Integumentary:	☐None	☐Psoriasis	☐Dermatitis			
Cardiovascular:	☐None	☐Heart Disease	☐High Blood Pressure History			
Musculoskeletal:	☐None	☐Arthritis	☐MS			
Respiratory:	☐None	☐Asthma	☐COPD	☐Bronchitis		
Hematologic, lymphatic:	☐None	☐High cholesterol	☐Anemia	☐HIV		
Neurological:	☐None	☐Headaches	☐Stroke	☐Dizziness		
Social:	☐None	☐Current Smoker	☐Former Smoker	☐Social Drinking	☐Daily drinking	

Do you have a family history of: (Mark all that apply)

☐Cataracts ☐Glaucoma ☐Macular degeneration ☐Hypertension
☐Diabetes ☐Cancer ☐Heart disease ☐Other eye disease:_____

Occupation:_____ Gender:_____ Race:_____
Hispanic or Latino? ☐Yes ☐No Currently Pregnant? ☐Yes ☐No ☐N/A Currently Nursing? ☐Yes ☐No ☐N/A

Reason for Today's Visit:_____

Visual Field Screening for Detection of Visual Disorders:
Automated visual field screening is a technologically advanced method used to assess both central and peripheral fields of vision for major defects. It is specially useful in detecting certain types/stages of glaucoma, brain tumors, aneurysms, strokes, and other ocular/neurological disorders. Our doctors recommend this quick and accurate test for all patients.
This test is not covered by insurance for screening purposes. The fee for the test is $25.
Do you want to have this test performed? ☐Yes ☐No

_____ _____/_____/_____
Signature of Patient (Parent/Guardian if patient is under 18) Date

Patient's Name:_____ Date of Birth:_____/_____/_____

Contact Lens Fitting Consent:

- I agree not to begin wearing contact lenses until I am trained on and can demonstrate proper insertion, removal, and care of them by an eye care professional.

- I understand that a contact lens prescription can not be finalized until the appropriate trial period and necessary follow ups are completed.

- I understand that wearing contact lenses comes with possible complications, such as inflammation and infections, which have the potential of causing temporary (or in rare cases permanent) vision loss. I understand that such risks are significantly higher with sleeping in contact lenses, therefore contact lenses must be taken out and properly cleaned and stored before sleeping.

- I understand that daily disposable contact lenses must be disposed of after one day of wear.

- Other factors that increase the risk of contact lens-related complications included improper care of contact lenses, not replacing disposable contact lenses according to the recommended schedule, and swimming/showering in contact lenses.

- I understand that if I experience symptoms such as redness, irritation, eye pain, burning, reduced vision, and/or other complications, I must discontinue contact lens wear immediately and follow up with my eye doctor or the emergency room as soon as possible.

- I understand that contact lenses are medical devices and prescribing them requires a higher level of professional judgment and liability than a routine exam, therefore there is an additional fee to have a contact lens prescription which may or may not be covered by my insurance plan. I understand that the contact lens evaluation fee covers up to three follow visits as needed within 90 days of the initial fitting.

- By signing below I accept these terms and I agree to be fitted with contact lenses if the doctor determines that I am a candidate.

_____ _____/_____/_____

Signature of Patient (Parent/Guardian if patient is under 18) Date