Welcome To Dr. Kristine-Hue Van & Associates,Inc.

Patient Information:

Mr. Mrs. Ms. Dr. Rev. First Name: _____ Middle name: _____ Last name: _____
Date of Birth:_____ Gender: Male Female Occupation: _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____
Phone # (Home) _____ (Work) _____ (Cell) _____ Last 4 digit of SSN _____

Who referred you to our office? _____ Have you been seen here before? Y N Last exam date _____
What is the reason for your visit today? ___Eye Exam ___Contact Lens Exam ___Office Visit
Are you planning to get new glasses today? Yes No Are you planning to get new contact lenses today? Yes No
Do we have permission to contact you via e-mail or text message if necessary? (Circle one) Y N

OPTOS[R] RETINAL IMAGING, OPTICAL COHERENT TOMOGRAPHY & MEIBOGRAPHY

We are proud to provide our patients with the state of the art digital scanning technology to have the best possible standard of care. These technologies allow our Healthcare professionals the ability to detect, diagnose, treat and manage various eye diseases including, but not limited to: Glaucoma, Macular degeneration, Diabetic retinopathy, Hypertensive retinopathy, Melanomas and Dry eye disease. Our Healthcare professionals **require** that all patients have a thorough examination of their retina each year.

The OPTOS[R] retinal imaging camera can be performed on dilated or non-dilated patients. It allows you the opportunity to see inside of your eyes just as the doctor sees it.

Optical coherent tomography (OCT) is an imaging technique that uses coherent light to capture very high resolution 2 and 3-dimensional images of the retina.

The Meibography is an imaging technology that allows us to evaluate the structures of the meibomian glands to detect dry eye disease.

Choose one: ___ OPTOS[R] Retinal Imaging $39
___ Wellness Scan (OPTOS[R] + OCT) $55
___ Wellness Scan Plus (OPTOS[R] + OCT + Meibography) $65

Eye History:	Self	Relative	**Systemic History:**	Self	Relative		Self	Relative
Cataract	☐	☐	HIV	☐	☐	Ulcers/Gerd/Acid Reflux	☐	☐
Glaucoma	☐	☐	Cancer	☐	☐	Sinus Problems	☐	☐
Diabetic Retinopathy	☐	☐	Diabetes	☐	☐	Hearing Loss	☐	☐
Macula Degeneration	☐	☐	Hypertension/Heart D.	☐	☐	Hay Fever	☐	☐
Retinal Detachment	☐	☐	Stroke	☐	☐	Emphysema	☐	☐
Dry Eye Disease	☐	☐	Multiple Sclerosis	☐	☐	Lupus	☐	☐
Floaters/Flashes of Light	☐	☐	High Cholesterol	☐	☐	Anxiety	☐	☐
Eye Injury/Trauma	☐	☐	Asthma	☐	☐	Depression	☐	☐
Eye Surgery	☐	☐	Thyroid Disease	☐	☐	Arthritis/Rheumatoid Arthritis	☐	☐
Type of Surgery _____			Seizures	☐	☐	Migraines	☐	☐
Date of Surgery _____			Kidney Disorder	☐	☐	Others _____	☐	☐

Medications:

Tobacco Use: Y N
Women: Are you currently pregnant? Y N Breast Feeding? Y N
Last Health Physical: _____

Drug Allergies:

---------- **HIPAA Consent and Payment Authorization** ----------

I hereby authorize Dr. Kristine-Hue Van & Associates, Inc. to obtain my medical information to assist in the care of my health. This information may be disclosed and used to carry out my treatment, to obtain payment from insurance companies, and for health care corporations like quality reviews. I have been offered a copy of the clinic's Privacy Notice for a more complete description of uses and disclosures before signing this consent. I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices from this clinic. I understand that I have a right to request a restriction of how my protected health information is used. I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed. I authorize any necessary medical treatment by the optometrist in this clinic. I further authorize this clinic to release or obtain any required medical information from my attending physicians or any medical facility.

Your insurance is meant to serve as a financial aid. We are happy to take assignment on your benefits. If you are not eligible for these benefits or are eligible for less than full coverage, **your signature indicates that you agree to be financially responsible for the balance not paid by your plan.** Our office staff will make every effort to verify benefits for you. **VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.** Payment for exam fees are due at the time of service. Insurance information must be presented before services are rendered. Professional fees cannot be refunded. I am aware that I have 90 days from the date of service to finalize my contact lens prescription or for a spectacle prescription check without a charge. I agree to pay any balances not covered by my insurance within 30 days.

Signature:_____Date:_____