Patient Name:_____ D.O.B:_____Sex:_____
Patient Email:_____ Phone:_____
Address: _____ City:_____ State:_____ Zip:_____
Preferred Pharmacy: _____Address:_____

VISION PLAN
Insurance Plan Name:_____ Member ID #:_____
Group #:_____ Primary Card Holder:_____
D.O.B:_____
Primary Card Holder SSN:_____ Relationship to Patient:_____

PRIMARY INSURANCE PLAN
Insurance Plan Name:_____ Member ID #:_____
Group #:_____ Primary Card Holder:_____
D.O.B:_____
Primary Card Holder SSN:_____ Relationship to Patient:_____

DILATION AND ADDITIONAL TESTS

We are pleased to provide our patients with an advanced scanning laser photo system called Optomap. This allows the doctor to screen for diabetes, glaucoma, and other diseases without dilation drops. **DILATION IS REQUIRED OTHERWISE. WE NO LONGER PERFORM EYE EXAMINATIONS WITHOUT EITHER CHOICE**

- ☐ **I agree to have Optomap photos instead of dilation. I understand the fee is $39.**
- ☐ **I agree to dilation**

Please check the box below if you would like a peripheral vision field screening. This test is very helpful in detecting visual defects that may occur such as in glaucoma, diabetes, and/or macular degeneration.

- ☐ **I agree to the visual field screen screening. I understand the fee is $20.**

PRIVACY PRACTICES ACKNOWLEDGEMENT AND RECEIPT

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be completed and updated annually by the patient or guardian:

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give Cedar Park Eye Care providers and employees my permission to discuss freely my condition, treatment or diagnosis with that person present.

☐ **YES** ☐ **NO**

By signing below, I acknowledge that I have been provided a copy of this facility's Notice of Privacy Practices Form (Rev. 10/2019) for review and a personal copy to keep will be provided upon request. If you have any questions about this notice, please contact the Facility Privacy Officer at (512)249-0808.

Signature of Patient or Guardian: _____ Date: _____
Relationship to Patient: _____ (i.e., Self, Parent)

PERSONAL HEALTH INFORMATION RELEASE (PHI)

This release authorizes Cedar Park Eye Care to discuss medical information regarding my care, lab or imaging results, condition, treatment or diagnosis, and account information with the following:

☐ Patient only ☐ Other:_____ Relationship:_____ Phone:_____

The following people may pick up medication samples and/or prescriptions on my behalf:

☐ Patient only ☐ Other:_____ Relationship:_____ Phone:_____

Signature of Patient of Guardian:_____ Date:_____
Relationship to Patient:_____ (i.e., Self, Parent)

MEDICAL HISTORY

Date ___/___/_____

When was your last eye exam? _____ When was your last medical exam? _____
Referring Doctor (letters, etc.) _____
Do you have any of the following medical conditions? (Self, Father, Grandmother, Daughter, Etc.)

☐ Cataract	_____	☐ Arthritis	_____
☐ Glaucoma	_____	☐ Diabetes Type 1 or 2	_____
☐ Macular Degeneration	_____	☐ High Blood Pressure	_____
☐ Retinal Detach/ Disease	_____	☐ Cancer	_____
☐ Lupus	_____	☐ Lazy Eye	_____
☐ Heart Disease	_____	☐ Thyroid Disease	_____
☐ Seizure Disorder	_____	☐ Keratoconus	_____
☐ Crossed Eyes	_____	☐ Dry Eyes	_____

Have you had any medical surgeries in the past? Please list them here: _____
_____
Do you wear glasses? ☐ Yes ☐ No If yes, how old are your glasses? _____
Do you wear contact lenses? ☐ Yes ☐ No If yes, what kind of contacts? ☐ Rigid ☐ Soft ☐ Hybrid
How often do you replace your contacts? _____ Are they comfortable? ☐ Yes ☐ No
How many hours are you on the computer each day? _____
Are you interested in information regarding LASIK? ☐ Yes ☐ No
Do you take any medications, vitamins, or supplements? ☐ Yes ☐ No
If yes, please list them here:
_____
_____
Have you had LASIK or Cataract surgery in the past? ☐ LASIK ☐ Cataract If so, when? _____
Do you have any allergies? ☐ Yes ☐ No
If yes, please list them here: _____
Do you use any tobacco, cigarette, or e-cigarette products? ☐ Yes ☐ No
If yes, what kind and how often? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Please check all that apply:

Eyes:
☐ Poor vision
☐ Eye Pain
☐ Tearing
☐ Redness
☐ Jaw Pain
☐ Scalp Tenderness
☐ Amaurosis Fugax
☐ Loss of Vision

Constitutional:
☐ Fever
☐ Chills
☐ Weight Loss

Respiratory:
☐ Cough
☐ Congestion
☐ Wheezing
☐ Shortness of Breath

ENT and Mouth:
☐ Stuffy Nose
☐ Ear Ache
☐ Dry Mouth

Cardiovascular:
☐ Rapid Heart Beat

Gastrointestinal:
☐ Upset Stomach
☐ Diarrhea
☐ Constipation
☐ Burning on Urination
☐ Urinary Frequency
☐ Incontinence

Musculoskeletal:
☐ Joint Pains
☐ Stiffness

Integumentary:
☐ Changing Moles
☐ Rash

Neurological:
☐ Headache
☐ Seizure
☐ Stroke
☐ Paralysis

Psychiatric:
☐ Anxiety
☐ Depression
☐ Insomnia

Endocrine:
☐ Thyroid Abnormalities

Hematologic:
☐ Bleeding
☐ Anemia

Immunologic:
☐ Allergies
☐ Hay Fever
☐ Hives

Other:
☐ Artificial Heart Valve
☐ Artificial Joints(within 2 years)
☐ Blood Thinners
☐ Narrow Angles
☐ Pregnancy
☐ Pseudoexfoliation Syndrome
☐ Elevated Blood Sugar

Name: _____ CEDAR PARK EYE CARE.COM Date: _____

COVID-19 Waiver

By signing this form you acknowledge that you do NOT have any of the following symptoms or have done any of the following activities.

I have not been in close contact with or cared for someone diagnosed with COVID-19 within the last 14 days.

I have not experienced any of the following cold or flu-like symptoms in the last 14 days:

- excessive cough, fever, sore throat, shortness of breath

X _____

Eyeglass Purchases & Contact Lens Wearers

Please be advised if you would like a prescription for contact lenses, you are responsible for a contact lens examination every year which includes 90 days of follow up care. This fee is an addition to your glasses examination & varies depending on the type of contact lens fitted and is assessed by the doctor during your examination. Glasses purchased have a 90 day remake policy from date of purchase for lenses only. A 25% restocking fee will be assessed for all cancelled orders.

X _____

Financial Responsibility

I authorize payment of my medical benefits to the undersigned physician / supplier for services rendered and/or products provided. I understand that Cedar Park Eye Care will make every effort possible to bill my insurance company and obtain all the necessary information for proper billing in advance of the services. I also understand that if Cedar Park Eye Care is unable to obtain authorization from my insurance company or if my insurance company fails to cover the services and materials, I WILL BE PERSONALLY FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED AND PRODUCTS DELIVERED AND/OR PROVIDED. I am responsible for all accounting fees in the event of my non-payment. There is a $50 no-show and cancellation policy in effect if no notice given within 24 hours of your visit and $50 returned check policy.

X _____

Annual Contact Lens Agreement

- If your Rx changes, we will exchange contact lenses purchased from us. Boxes must be resalable, i.e. no marks, no writing, no torn or missing labels and must be factory sealed.

- Contact Lenses are medical devices which should be monitored by the doctor to determine the current prescription and health of the eyes to ensure successful contact lens wear.

- I understand that annual exams and sometimes 6 month corneal evaluations are necessary to continue replacing contacts.

- I understand that there is an increased risk of infection, corneal ulcers that can lead to loss of vision or blindness with contact lens wear. The risk increases significantly if the contacts are worn while sleeping, either 10 minutes or 10 hours. Complying with wearing times, care regimens and disposal schedules minimize this risk.

- I understand that if sudden or prolonged redness, pain or irritation of the eyes occurs, I should remove the lenses and call this office immediately.

- I understand that topping off the solution in my case every night instead of replacing it can lead to permanent vision loss.

X _____