natomas optometry

# Welcome to our Office!

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*The doctors and staff of Natomas Optometry are fully committed to you and your family's total eye health and vision wellness. We utilize state-of-the-art eye care and the finest eyewear products available in an atmosphere of uncompromised service, value, and friendliness. Our mission is to provide the highest quality of life for you and your family.*

Date _____

Name _____ M / F

Address _____(include apt/unit# if any)

City _____State _____Zip _____

Phone: Home_____ Cell_____ Work_____

Email (required): _____

D.O.B _____Age _____Social Security # _____

Occupation _____ Employer _____

Hobbies / Sports _____

Name of Parents or Spouse _____

Referred by ☐ Insurance Website ☐ Friend / Family _____
☐ Yelp ☐ Facebook
☐ Online review ☐ Drive by
☐ Internet Search ☐ Other _____

Primary Insurance Information:

Vision Plan: ☐ VSP ☐ MES ☐ EyeMed ☐ Other _____

Member Name _____ Relation to patient_____

Member ID (SS#) _____ Member DOB _____

Member's Employer _____

Member's Address (if different): _____

Any Secondary Insurance from spouse or parent? Please complete:

Vision Plan: ☐ VSP ☐ MES ☐ EyeMed ☐ Other _____

Member Name _____ Relation to patient_____

Member ID (SS#) _____ Member DOB_____

Member's Employer _____

# Medical History Questionnaire

Date of last eye exam _____ Doctor _____

Are you interested in New Glasses? ☐ yes ☐ no
Are you interested in Contact Lenses? ☐ yes ☐ no
Are you interested in Sunglasses? ☐ yes ☐ no
Are you interested in Laser Vision Correction? ☐ yes ☐ no

Check if you have any of the following Visual Conditions:

| | | |
|---|---|---|
| ____ Blur at Far / Near | ____ Dry Eyes | ____ Glaucoma |
| ____ Eye Infections | ____ Eye Pain | ____ Cataracts |
| ____ Eye Injury / Surgery | ____ Flashes/Floaters | ____ Double Vision |

Family Physician: _____ Last Medical Exam _____

Check if you have any of the following Medical Conditions:

| | | |
|---|---|---|
| ____ Diabetes | ____ Allergies | ____ Headaches |
| ____ High Blood Pressure | ____ Thyroid Disease | ____ Arthritis |
| ____ High Cholesterol | ____ Heart Attack/Stroke | ____ Asthma/Bronchitis |

Are you pregnant or nursing? ☐ yes ☐ no

Check if there is a Family History of the following:

| | | |
|---|---|---|
| ____ Blindness | ____ Macular Degeneration | ____ Diabetes |
| ____ Glaucoma | ____ Cataracts | ____ High Blood Pressure |

List ALLERGIES to Medications: _____

List CURRENT MEDICATIONS…and the CONDITION for which it was prescribed:

_____ to treat⇒_____
_____ ⇒ _____
_____ ⇒ _____
_____ ⇒ _____
_____ ⇒ _____

Please include any other pertinent eye or medical information:

OFFICE POLICIES

1. Payment is due at the time of services. Unpaid accounts more than 60 days past due may be transferred to an outside agency for collection.
2. Any denied insurance claims become the patient's responsibility to pay.

_____ _____
Signature of patient, parent, or guardian Date

# Receipt of Notice of Privacy Policies & Consent Form

Natomas Optometry
4130 Truxel Rd, Ste D
Sacramento, CA 95834
(916) 928-8383
Fax (916) 928-8380

Patient Name: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, refer you to other healthcare professionals, to obtain payment from your insurance company for our services, and to conduct general health care operations involving our office. Please sign below to signify that you allow us to disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Natomas Optometry.

_____ _____

Signature of patient or parent / guardian Date