OPTIC GALLERY

Family Eye Care

WELCOME TO OUR OFFICE

To help us take better care of you, please provide us with the following information

Today's Date: ______________

Patient Name ______________________________ Sex (M/F)______ Date of Birth ___/___/_____Age _____

Address ______________________________ City______________ State ________Zip __________

Primary Phone # ____________________ (Home/Work/Cell) Alternate Phone # ______________(Home/Work/Cell)

Social Security # ______________________________ E-Mail Address ______________________________

Place of Employment ______________________________ Occupation ______________________________

How were you referred to our office? ______________________________

Insurance Information

Insured's Name__________________________ Insured's S.S.# ______________ Insured's DOB ______________

Medical Insurance________________ Medical Insurance # ______________ Vision Insurance ______________

PERSONAL & FAMILY MEDICAL HISTORY

Name of Primary Physician ____________________ Last Physical Exam ____________________

Do you? **Drink** ▢ YES ▢ NO _________ **Smoke** ▢ YES ▢ NO _________ **Drug Use** ▢ YES ▢ NO_________

Are you pregnant or nursing? ▢YES ▢NO

Do *you* have or have you had any of the following eye conditions:

- ▢ I have no ocular conditions
- ▢ Glaucoma
- ▢ Cataracts
- ▢ Eye Surgery (LASIK etc.) If so, when? ____________________
- ▢ Macular Degeneration
- ▢ Eye Injury
- ▢ Lazy eye or eye turn
- ▢ Other: ____________________

Does anyone in your ***immediate family*** have any of the following? Who?

- ▢ Glaucoma ________________
- ▢ Cataracts ________________
- ▢ Blindness ________________
- ▢ Eye Disease ________________
- ▢ Diabetes ________________
- ▢ Macular Degeneration__________
- ▢ Cancer ________________
- ▢ High Blood Pressure __________
- ▢ Heart/Lung Disease __________
- ▢ Other: ________________

Please Indicate if *you* have any of the following health conditions:

- ▢ I have no medical conditions
- ▢ Allergies/Hay Fever
- ▢ Asthma
- ▢ Cancer
- ▢ Diabetes
- ▢ Kidney Disease
- ▢ Thyroid Problems
- ▢ Headaches/Migraines
- ▢ Heart Disease
- ▢ High Blood Pressure
- ▢ High Cholesterol
- ▢ Lung Disease
- ▢ Sinus Problems
- ▢ Other: ____________________

Please provide us a list of any medications you currently take:

____

Do you have any medication allergies? ▢ YES ▢ NO ______________________________

About your vision

Are *you* experiencing any of the following? Check all that apply.

- ▢ Headaches/Migraines
- ▢ Double Vision
- ▢ Dry/Burning Eyes
- ▢ Itchy Eyes
- ▢ Sensitivity to light
- ▢ Floaters/Light Flashes
- ▢ Eye Pain or Soreness
- ▢ Eye Turn or Lazy Eye
- ▢ Loss of Vision
- ▢ Chronic Eye Infections
- ▢ Other Eye Discomfort

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Date of last *eye* exam ______________________ Where? ______________

Reason for today's visit? ______________________________

Please list any activities and hobbies ______________________________

____

Do you wear glasses? ▢ YES ▢ NO   Do you wear Sunglasses? ▢ YES ▢ NO

How old are your glasses? ______________________________

Does your work require any special vision needs? ▢ YES ▢ NO If so, what? ______________

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Do you wear contact lenses? ▢ YES ▢ NO   What type? ______________

Do you use eye drops? ▢ YES ▢ NO   What type? ______________

What contact solution do you use? ______________________________

Dilation of your eyes

It is necessary for the doctor to dilate your pupils in order to perform a complete and thorough eye examination. Dilation allows the doctor to obtain a better view of the back of your eyes. The dilating drops typically last 3-4 hours. During this time you may find it difficult to focus at near and less commonly at distance. You may be sensitive to light and will be provided with post-dilation glasses. We strongly recommend caution when driving or operating equipment or machinery after dilation. If you feel you would not be able to drive or return to work, we recommend digital retinal photography and/or OCT in place of dilation. Signing below signifies you have been informed of the risks and benefits of having the Doctor perform dilation during your exam today. **Please select one of the options below.**

▢ I wish to have dilation performed today. ▢ I do not wish to have dilation performed today.
▢ I wish to discuss dilation with the doctor.

Signature (Patient or Guardian) ______________________ Date ______________

NOTICE OF PRIVACY PRACTICES

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, obtain payment for these services, and to conduct healthcare operations involving our offices. I authorize Optic Gallery and/or any of its associates to release and/or request these records. If applicable, I request that payment of authorized insurance be made to Optic Gallery and/or any of its associates for any services rendered to me. I authorize pertinent medical information about me to be used to determine insurance benefits and billing to be released to the health care financing or other insurance agencies. The Notice of Privacy Practices you may have been given describes these uses and disclosures in detail.

FINANCIAL RESPONSIBILITY POLICY

Payment for services provided by Optic Gallery is required at the time of services unless prior arrangements have been made. Co-pays, co-insurance, deductibles, and/or non-covered services are due at the time of service, no exceptions. If we are contracted with your insurance company, we will bill your insurance policy as a courtesy to you. Understand it is ultimately your responsibility as the patient to know your insurance coverage. We encourage every patient to know their medical benefits, if you need further clarification contact your insurance company directly. Although Optic Gallery does contact your insurance company for benefits, please be aware that benefits quoted to Optic Gallery is not a guarantee of benefits and/or payment. Co-insurance and allowable information given to Optic Gallery is an estimate and further payment may be required after your claim has been paid. Exact payment is not determined until your claim is processed by your insurance company.

I understand it is policy of this office to require:

1. **Payment in full or at least one half before an order can be placed.**
2. **The balance of the fee be paid at the time the order is dispensed.**
3. **All orders are final when placed.**

Your signature below indicates that you understand and agree to all policies listed above and understand you are responsible for any charges by your insurance. You also are acknowledging that you have read and/or received a copy of this *Notice of Privacy Policy & Financial Responsibility Policy.*

Signature (Patient or Guardian):______________________________ **Date**_______________

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

It is our policy at Optic Gallery to ensure that the health care information of all patients is kept confidential. It is the right of all patients to receive full consideration of privacy and confidentiality with regard to all information and records about their care. It is necessary for us to get your authorization on certain items.

I AUTHORIZE THE STAFF OF OPTIC GALLERY TO CALL AND LEAVE MESSAGES ON MY ANSWERING MACHINE/PERSONAL VOICEMAIL AND SEND EMAIL(S) REGARDING:

Please list anyone we may speak to on your behalf ______________________________

- ❑ My Appointment(s)
- ❑ My Medical Care/Results
- ❑ My Patient Account/Billing
- ❑ When I am due for my annual exam

I UNDERSTAND AND AGREE THAT THIS PRACTICE MAY USE AND DISCLOSE MY HEALTH INFORMATION IN ORDER TO:

- Make decisions about and plan for my care and treatment.
- Refer to consult with, coordinate among and manage, along with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative, and business functions that support my optometrist's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I UNDERSTAND THAT THE NOTICE OF PRIVACY PRACTICES MAY BE REVISED FROM TIME TO TIME, AND THAT I AM ENTITLED TO RECEIVE A COPY OF ANY REVISED NOTICE OF PRIVACY PRACTICES. I UNDERSTAND AND AGREE THIS RELEASE WILL REMAIN VALID AND IN PLACE UNTIL REVOKED BY ME IN WRITING.

PATIENT NAME: ______________________________

PATIENT SIGNATURE: ______________________________ **DATE:** ______________

❑ **This patient is a minor. Guardian Signature:** ______________________________

I have been given a copy of the Notice of Privacy Practices and Patient's rights and responsibilities form: ______________________ **(initial)**

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CORONAVIRUS SCREENING

Patient Name: ______________________________ DOB: _____________

Have you been out of the country within the past 2 weeks?

☐**YES** ☐**NO**

Have you been in close contact with someone known to have a coronavirus (COVID-19) illness?

☐**YES** ☐**NO**

Do you have a fever, cough, or difficulty breathing?

☐**YES** ☐**NO**

Current temperature: _______________

If you answered *yes* to any of the above questions and/or have a current temperature above 99 degrees Fahrenheit, your appointment may be cancelled.

Patient Signature____

Date_______________ Time__________