

THE FOLLOWING INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female Date \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_

e-mail: \_\_\_\_\_ Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you have vision care insurance?  Yes  No

Primary Vision Insurance:

Insurance Company: \_\_\_\_\_

Insurance Address \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ ID # \_\_\_\_\_

Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_ Group # \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_ Patient Relationship to Subscriber:  Self  Spouse  Child  \_\_\_\_\_

Additional vision insurance:

Insurance company \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Group # \_\_\_\_\_

Please Note: The Doctor's fees are billed separately from the optical fees (glasses & contacts). There are several insurance companies we can bill directly for you. If yours is not one of these, we will provide you with a receipt after payment showing appropriate codes so you may submit it to your insurance company. There is an **extra fee for the measuring & fitting of contact lenses**, which is required to be done at each and every exam if you wish to have a prescription for contact lenses. If you are a previous contact lens wearer or renewing your contact lens prescription, you must still be fitted for lenses, due to the fact that your cornea shape may change over time. **Most insurance companies will not pay for a contact lens fit and evaluation exam. The contact lens fit and evaluation fee is your responsibility.**

OFFICE FINANCIAL POLICY AND AUTHORIZATION TO BILL YOUR INSURANCE

I understand that I must pay any balances including all co-pays and estimated portions not covered by my insurance company at the conclusion of today's visit.

If you have insurance, we will submit your claim for you. Please be advised that all charges incurred at our office are ultimately **your responsibility**. If payment is not received from your insurance company, you will be required to pay the balance. A finance charge computed at a periodic rate of 1.5% per month will be added to past due accounts, plus collection cost and attorney fees incurred by Optical Reflections, LLC.

I hereby consent to and authorize the administration of all treatments as deemed necessary by the attending physician. I authorize my insurance benefits to be paid directly to the physician. I also authorize the doctor to release any information required by my insurance company. No other records shall be released without my signed consent. YES / NO

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that I have received a Notice of Privacy Practices regarding the use and disclosure of my health information. I understand that this may change in the future and that I may contact this office at any time to obtain a current copy of the Notice. I understand that I may request in writing reasonable restrictions of the use of my information for the purposes of treatment, payment or health care operations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(OVER)

List any allergies to medicines: \_\_\_\_\_

List any medications you take (including birth control pills, aspirin, over the counter medications and home remedies)

Are you pregnant or nursing?  Yes  No

Date of Last Comprehensive Eye Exam: \_\_\_\_\_

Do you wear glasses?  Yes  No If yes, how old is your prescription? \_\_\_\_\_

Do you wear contact lenses?  Yes  No If yes, how old is your current pair? \_\_\_\_\_

What type of contact lenses:  Disposable Soft Lenses  Standard Soft Lenses  Rigid Lenses

If you use disposable lenses how often do you throw them away? \_\_\_\_\_

Do you wish to be measured for contact lenses today  Yes  No

Do you ever sleep with your lenses on?  Yes  No

Have you ever had refractive surgery?  Yes  No If yes, specify type:  RK  PRK  LASIK

Are you interested in refractive surgery?  Yes  No

**Personal/Family History**

Please answer the questions below regarding you or your immediate family (parents, grandparents, siblings, children):

	You		Family			How are they related to you?
	Yes	No	Yes	No	?	
Blindness/Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**ROUTINE PUPIL DILATION**

I authorize the attending doctor to dilate my pupils. I understand that the dilating drops may cause some blurring of my vision. YES / NO

**Optical Reflections, LLC**