

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 _____
ID # _____
Subscriber's Name: _____ Date of Birth _____ Group # _____
Employer _____ Patient Relationship to Subscriber: Self Spouse Child _____
Person Responsible for Payment _____

Additional vision insurance:
Insurance company _____ ID# _____
Subscriber's name _____ Date of Birth _____ Group # _____

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 lens. 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
WE DO NOT BILL SECONDARY 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.

As a courtesy to our patients, we will bill all major medical insurance companies that allow us to do so. We request that you furnish us with complete billing information at the time of your visit. If that information is not given or is incorrect, you will be responsible for the balance in full.

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 are ultimately responsible for the bill and payment in full is required within thirty (30) days from the original date of service. 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

Work at a computer for long periods? _____

Hobbies _____

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