WELCOME TO OPTOM~EYES - PLEASE PRINT LEGIBLY AND COMPLETE ALL ITEMS

Patient's Name _____ _____
Legal Last First MI *Name patient prefers to be called*

Name of guarantor (required if patient is a minor) _____

Address _____ City _____ State _____ Zip _____

Home Phone_____ Work Phone_____ Cell Phone_____
Please circle: Patient /Mother / Father / Guardian Patient /Mother / Father / Guardian

e-mail_____

What's the best way to contact you? *Please circle* H/W/C Phone; Email; Text Preferred Language: English/Spanish

With whom (if anyone) may we discuss your personal information?_____

Patient's Race: American Indian or Alaska native/Asian/Black or African American/Hispanic/Native Hawaiian or other Pacific Islander/White

Patient's Ethnicity: Hispanic or Latino/Native Hawaiian or other Pacific Islander/None of the previous

Patient's Sex: M/F Patient's Marital Status (circle one): Single/Married/Divorced/Other

Patient's Date of Birth _____ Patient's Social Security Number_____

Patient's Employer/School_____ Patient's Occupation_____

Employment Status: Employed full time/Student full time/Not a student

Name of primary care physician (PCP) _____ PCP phone _____

How did you hear about OPTOM~EYES?_____ Date of Last Eye Exam _____
Where? _____

Have you been seen before at OPTOM~EYES? Yes / No When?_____

PATIENT'S QUESTIONNAIRE: Do you wear contact lenses? Yes / No Are you interested in contact lenses? Yes / No

DILATION CONSENT: The use of dilating drops is the standard for the most thorough eye examination; it is the only way of providing a complete ocular health assessment. You may experience increased light sensitivity and some difficulty seeing up close, although there is generally little effect on distance vision. These effects can last anywhere from 2 to 5 hours. There is no additional fee for dilation.

CHECK ONE, PLEASE: I accept dilation _____ I decline dilation _____ I'd like to reschedule dilation _____

CONTACT LENS SERVICES: The initial fitting fee (additional to the routine exam fee) covers follow-up visits during the trial period (up to a month) - additional appointments will be billed as routine office visits.

RETINAL IMAGE/OCT AUTHORIZATION (Please review attached information sheets prior to completing this part): Dr. Rabins recommends retinal/OCT screenings for all of his patients and we will perform these diagnostic tests at an additional cost to the comprehensive eye exam being performed today. Please select one of the following boxes:

☐ I'D LIKE TO have my/my dependent's retinal health evaluated with retinal imaging/optical coherence tomography. I understand that I will be billed $40 separately for this packaged service.

☐ I DECLINE retinal imaging/optical coherence tomography. I understand that I/my dependent will still receive a thorough eye examination with ordinary slit lamp and indirect biomicroscope observation.

Signature of Patient or Parent/Guardian _____ Today's Date _____

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES: I acknowledge having had opportunity to review the OPTOM~EYES Notice of Privacy Practices and understand I may keep a copy for my personal files if desired.

SIGNATURE _____

☐ **Check here if you do not have insurance.**

VISION INSURANCE POLICY INFORMATION – please notify receptionist if you have more than one policy

Primary Insurance _____ ID / Policy #: _____ Group #: _____

IF POLICY HOLDER IS NOT THE PATIENT:

Policy holder _____ Soc. Sec.#_____
Last First Initial (may be necessary for insurance claim filing)

Relationship to Patient: _____ Policy holder's date of birth: _____

Address _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____

MEDICAL INSURANCE POLICY INFORMATION – please notify receptionist if you have additional coverage

Insurance Company: _____ Phone: (_____)_____

Insurance ID / Policy #: _____ Group #: _____

IF POLICY HOLDER IS NOT THE PATIENT:

Policy holder _____ Soc. Sec.# _____
Last First Initial (may be necessary for insurance claim filing)

Relationship to Patient: _____ Policy holder's date of birth: _____

Address _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____

FOR MEDICARE PATIENTS ONLY: Have you met your out-patient deductible for this year? ☐ Yes ☐ No
Do you have a Medicare supplemental policy? ☐ Yes ☐ No If yes, name of insurance company: _____

FINANCIAL RESPONSIBILITY

Note: As a courtesy to our patients, OPTOM~EYES will file insurance claims for **contracted insurance companies**; however all copayments are due when services are rendered. Any additional charges (such as for deductibles or non-covered charges) will be billed to the policy holder. We do not file out-of-network claims, but will assist in filing such claims upon request. Payment from these companies will be directly to the policy holder and may be at a reduced rate. If you have any questions, please speak to the receptionist before your exam.

For contracted insurances: I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I also understand that any non-covered charges (such as refraction) will be billed at OPTOM~EYES' usual and customary rates, and that I am responsible for all deductibles. I hereby authorize OPTOM~EYES to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

FOR ALL: *I understand that I am ultimately responsible for all charges accumulated. In addition, I understand that if this account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including interest (18% per annum, on the unpaid balance), legal fees, and collection agency costs. Returned checks will be assessed a $50 service charge.*

SIGNATURE _____ **PRINTED NAME** _____

Please take a few minutes to complete this health information form.

Name: _____ Date: _____

Do you wear glasses? ☐ Yes ☐ No

Do you ever wear contacts? ☐ Yes ☐ No Are you currently wearing them? ☐ Yes ☐No

Do you use tobacco? ☐ Yes ☐ No Do you use alcohol? ☐ Yes ☐ No

Are you having any blurred vision? ☐ Yes ☐ No Is the blurred vision with or without glasses? ☐ With ☐ Without

Do your eyes ever feel Dry or Itchy? ☐ Yes ☐ No Have you had any headaches in the last month? ☐ Yes ☐ No

Primary Care Physician (PCP) _____ PCP Phone _____

Please check any that apply:

PART 1: EYE HEALTH

☐ Bloodshot eyes
☐ Flashes of light
☐ Color blind
☐ Crossed eye
☐ Double vision
☐ Lazy eye
☐ Eye infection
☐ Eye injury
☐ Eye strain
☐ Cataract
☐ Floaters or spots
☐ Glaucoma
☐ Macular degeneration
☐ Retinal detachment
☐ Seeing halos
☐ Watering eyes
☐ Blindness
☐ Eye surgery

PART 2: MEDICAL HISTORY

☐ Anxiety
☐ Arthritis
☐ Artificial heart valve
☐ Asthma
☐ Cancer
☐ Chemical dependency
☐ Currently pregnant
☐ Depression
☐ Diabetes (Type ___)
☐ Emphysema
☐ Epilepsy
☐ Fibromyalgia
☐ Hay fever
☐ Heart condition
☐ Hepatitis (Type ___)
☐ High blood pressure
☐ High cholesterol
☐ Kidney disease
☐ Lupus
☐ Skin condition
☐ Stroke
☐ Thyroid condition

Height _____ Weight _____

PART 3: FAMILY HISTORY

☐ Blindness
☐ Cataract
☐ Diabetes
☐ Glaucoma
☐ High blood pressure
☐ Keratoconus
☐ Lazy eye
☐ Macular degeneration

List all medications you currently take, including supplements (or provide list).

_____

_____

List all allergies to medications, eye drops or other substances.

_____

_____