Please note that our standard hours of operation are from 9:00AM to 5:30PM on normal business weekdays, although variable extended, weekend, and holiday hours may be available at times. We are not available for after-hours emergencies. In case of an after-hours emergency, if you feel like you cannot safely wait to visit us during standard hours, you should call your physician, go to or call the local emergency room, or call 911.

Have you ever had an exam at our office? **Y / N** If not, how did you hear about us? ____________________

PATIENT INFORMATION *(Please fill out completely, all information is confidential under our Notice of Privacy Practices terms)*

LAST NAME ____ FIRST NAME ____ MI ____ TITLE ____ DATE OF BIRTH ___/___/___

GENDER ____ MARITAL STATUS ____ EMPLOYER ____ SOCIAL SECURITY # ___-___-___

EMAIL ADDRESS ____ CONTACT PHONE # (___)___-___ WORK PHONE # (___)___-___

STREET ADDRESS ____ SUITE/APT # ____ CITY ____ STATE ____ ZIP CODE ____

LEGAL GUARDIAN/CAREGIVER INFORMATION *(Only if patient is under 18 years old or if otherwise applicable)*

LAST NAME ____ FIRST NAME ____ MI ____ TITLE ____ DATE OF BIRTH ___/___/___

GENDER ____ RELATIONSHIP TO PATIENT ____ CONTACT PHONE # (___)___-___ SOCIAL SECURITY # ___-___-___

STREET ADDRESS ____ SUITE/APT # ____ CITY ____ STATE ____ ZIP CODE ____

PRIMARY INSURED INFORMATION *(Only if other than patient and the guardian/caregiver listed above)*

LAST NAME ____ FIRST NAME ____ MI ____ TITLE ____ DATE OF BIRTH ___/___/___

GENDER ____ RELATIONSHIP TO PATIENT ____ CONTACT PHONE # (___)___-___ SOCIAL SECURITY # ___-___-___

STREET ADDRESS ____ SUITE/APT # ____ CITY ____ STATE ____ ZIP CODE ____

ADVANCE BENEFICIARY NOTICE *(Please read carefully)*

Our office participates with various medical and vision insurance carriers. Most **vision insurance plans are only intended for routine eye exams** to check the general health of the eyes and to determine vision correction prescriptions. Please note that **eye exams that are intended for and/or result in evaluation of the eye for a medical condition may need to be filed with a medical insurance plan.** Some common examples of such medical conditions are diabetes, high blood pressure, cataracts, glaucoma, dry eyes, and eye-related infections or allergies. The type of insurance plan needed for the visit can only be determined at the conclusion of the exam. Therefore our staff needs to collect information regarding both medical and vision insurance before the exam. As a courtesy, our office will promptly process insurance claims. However, the insurance coverage is a contract between the insured and the insurance company. The patient, guardian, and/or the insured is responsible for all applicable copays, coinsurances, deductibles, non-covered services, payment for any procedures rejected by the insurance company, and payment for any claim not paid within 60 days of filing.

PRIMARY VISION PLAN ____ POLICY # ____ GROUP # ____ OTHER VISION PLAN ____

PRIMARY MEDICAL PLAN ____ POLICY # ____ GROUP # ____ OTHER MEDICAL PLAN ____

INFORMED CONSENT AND AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION *(**Must read and sign**)*

By signing below I acknowledge that I have read, understood, and agreed to all information provided on this entire page, I accept that any medical and related financial record with regards to services rendered to the patient at this office may be shared with insurance companies listed above and/or with other healthcare providers and/or organizations that have participated in the patient's care, I authorize payment of insurance benefits for these services to the providing physician and/or supplier, and I give this office permission to request and access all necessary medical-related records from any other health care provider and/or organizations that have participated and/or will participate in the patient's care. I can cancel this authorization at any time. The authorization expires in 3 years.

PATIENT SIGNATURE *(Or guardian/caregiver if applicable)* ____ PRINTED NAME OF SIGNATORY ____ TODAY'S DATE ___/___/___

PRIMARY INSURED SIGNATURE *(Or authorized person)* ____ PRINTED NAME OF SIGNATORY ____ TODAY'S DATE ___/___/___

PATIENT MEDICAL HISTORY *(Please answer all questions)*

What is the patient's reason for today's visit? ______________________________

List all other problems the doctor should know about: ______________________________

____/____/____	______________________	____/____/____	______________________
LAST EYE EXAM DATE	LAST EYE DOCTOR OR FACILITY NAME	LAST PHYSICAL DATE	LAST PHYSICIAN OR FACILITY NAME

PRESENT/PAST ILLNESS OF:

	PATIENT AND	**FAMILY**
ARTHRITIS	**Y / N**	**Y / N**
ASTHMA/OTHER LUNG DISEASE	**Y / N**	**Y / N**
SEVERE BLINDNESS	**Y / N**	**Y / N**
CANCER/TUMOR	**Y / N**	**Y / N**
CATARACTS	**Y / N**	**Y / N**
DIABETES/PREDIABETES	**Y / N**	**Y / N**
GLAUCOMA	**Y / N**	**Y / N**
HEART DISEASE	**Y / N**	**Y / N**
HIGH BLOOD PRESSURE	**Y / N**	**Y / N**
HIGH CHOLESTEROL	**Y / N**	**Y / N**
LAZY EYE/EYE TURN	**Y / N**	**Y / N**
MACULAR DEGENERATION	**Y / N**	**Y / N**

Has the patient been experiencing any of the following?

DOUBLE VISION	**Y / N**	EYE PAIN	**Y / N**
SPOTS IN VISION	**Y / N**	FLASHES IN VISION	**Y / N**
FREQUENT HEADACHES	**Y / N**	SUDDEN VISION LOSS	**Y / N**

Does the patient smoke tobacco products? **Y / N**
If no, is he/she a former smoker? **Y / N**
Does the patient consume alcohol? **Y / N**
If yes, is it more than just social drinking? **Y / N**
Does the patient use recreational drugs? **Y / N**
Is the patient currently pregnant/nursing? **Y / N**
Is the patient in good general health? **Y / N**

Patient's current weight: __________ lbs **& Height:** __________ft

List all patient's eye/vision disorders not mentioned above: ______________________________

List all family's eye/vision disorders not mentioned above: ______________________________

List all patient's medical conditions not mentioned above: ______________________________

List all medications being taken by the patient: ______________________________

List all patient's allergies (including allergies to medications): ______________________________

List all patient's head/eye/vision-related injuries **with date:** ______________________________

List all patient's head/eye/vision-related surgeries **with date:** ______________________________

PATIENT REFRACTIVE HISTORY *(Please answer all questions)*

Does the patient wear prescription glasses? **Y / N**
If not, has he/she ever worn them? **Y / N**

Please check all that apply to any pair of glasses currently owned by the patient:

▯ SINGLE VISION	▯ DISTANCE ONLY	▯ NEAR ONLY
▯ PROGRESSIVES	▯ BIFOCALS	▯ TRIFOCALS
▯ OVER THE COUNTER	▯ SUNGLASSES	▯ BACKUP PAIR
▯ SPORTS GLASSES	▯ SAFETY GLASSES	▯ COMPUTER

Does the patient:

Have vision problems with current glasses?	**Y / N**
Have non-vision related issues with them?	**Y / N**
Spend many hours/week on the computer?	**Y / N**
Have trouble with glare and/or night vision?	**Y / N**
Need sunglasses?	**Y / N**
Need spare glasses?	**Y / N**
Have allergy to nickel (frames)?	**Y / N**

Has the patient ever been prescribed contact lenses? Y / N *(Circle **SOFT** or **HARD**)* **Is this exam for a contact lens prescription? Y / N**

INFORMED CONSENT AND ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES (***Must read and sign***)

By signing below I acknowledge that I have read, understood, and agreed to all information provided on this entire page, I understand that the patient's health information is confidential and this office works very hard to protect the patient's privacy, and I give this office authorization to release any necessary medical and related financial record of the patient to other healthcare, financial, and/or legal entities if necessary for treating the patient, collecting payment, and performing "health care operations". A detailed explanation of my rights as a patient of this office and the office policies and practices protecting those rights , including but not limited to situations where my medical records may be shared with certain individuals and/or organizations, is provided on a comprehensive document, called the "Notice of Privacy Practices" (NPP), which is available for my review. I acknowledge that I have read and understood the content of the NPP in its entirely and I wish for the patient to be treated at this office under the said terms. I also understand that the NPP may be updated and I have the right to review the most current version if I request.

	______________________	____/____/____
	PATIENT NAME	DATE OF BIRTH
______________________	______________________	____/____/____
PATIENT SIGNATURE *(Or guardian/caregiver if applicable)*	PRINTED NAME OF SIGNATORY	TODAY'S DATE

PUPIL DILATION INFORMED CONSENT

Based on medical history and exam findings the doctor may determine that it is necessary to dilate the pupils in order to make a better assessment of inside of the eye for potentially sight- and/or life-threatening conditions. This is done through administration of eye drops which may cause varying degrees of eye irritation and redness that normally last several seconds. Pupil dilation will also blur the patient's vision for a few hours. The blurriness is usually more noticeable in the patient's near vision, although the distance vision for certain individuals could be significantly reduced as well. The patient may also become more sensitive to light for a few hours and must wear sunglasses in bright environments as needed. Disposable sunglasses are also available at the front desk. While many patients drive themselves safely when dilated, each patient must use own judgment in deciding whether it's safe to drive based on his/her vision and level of comfort in doing so. Please note that in many cases it is ok to schedule the dilation part of the exam for another time, which must be within 30 days of the exam.

By signing below I agree that if the doctor determine pupil dilation to be necessary: *(Please select one)*

▯ I **permit** the procedure for today ▯ I will **schedule** to come back if its ok ▯ I **refuse** the procedure

PATIENT NAME _______________ DATE OF BIRTH ___/___/___

PATIENT SIGNATURE *(Or guardian/caregiver if applicable)* _______________ PRINTED NAME OF SIGNATORY _______________ TODAY'S DATE ___/___/___

VISUAL FIELD SCREENING INFORMED CONSENT FORM

Automated visual field screening is a technologically advanced method to assess both central and peripheral field of vision for major defects. It is especially useful in detecting certain types/stages of glaucoma, brain tumors, strokes, and various other ocular and neurological disorders. It may also assist the clinician in determining the cause of unexplained headaches. The test is non-invasive and takes approximately one minute per eye.

Professional Fee: $25.00
(Fee is not covered by insurance)

By signing below: *(Please select one)*

▯ I **permit** the procedure ▯ I **refuse** the procedure

PATIENT NAME _______________ DATE OF BIRTH ___/___/___

PATIENT SIGNATURE *(Or guardian/caregiver if applicable)* _______________ PRINTED NAME OF SIGNATORY _______________ TODAY'S DATE ___/___/___

CONTACT LENS INFORMED CONSENT FORM *(Only for contact lens exams.* ***Must read and sign****)*

Please be aware that contact lenses are medical devices regulated by the FDA, and as well as benefits, contact lens wear comes with potential risks. The risks include but are not limited to ocular irritation, infection, inflammation, allergic reactions, pain, contact lens intolerance, and potential permanent vision loss. These risks increase with extended wear, and it is highly recommended for all patients to remove lenses every day before going to sleep. If the patient choose to sleep in contact lenses, he/she assumes responsibility for such risks. As part of many requirements for the patient to be approved to start or continue contact lens wear, he/she must agree to use contact lenses based on the doctor's instructions, including but not limited to wear time, replacement schedule, and use of appropriate eye drops if indicated. It is necessary to inform the doctor if the patient plans on sleeping in contact lenses to ensure that appropriate lenses and wear schedule are selected. No patient under 18 years of age shall sleep in contact lenses prescribed at this office. Contact lens wearers must always wash and dry hands before insertion and removal of contact lenses, clean the contact lens with the disinfecting solution every time it comes out of the eye, clean the contact lens case with disinfecting solution on a daily basis, and replace the contact lens case at least once every three months, Contact lens wearers must avoid using any solution other than the disinfecting solution to clean/rinse the contact lens and/or its case, reusing disinfecting solution, leaving the case open, using non-approved eye drops with the contact lenses, and/or performing activities that could result in the lens coming in contact with water. If any unusual symptoms, including but not limited to changes to vision, eye pain, irritation, and/or redness is experienced by the patient, he/she must remove the contact lenses immediately and treat the situation as a medical emergency. A backup pair of glasses is strongly recommended for times, such as unexpected instances of temporary complications, that the patient is unable to wear contact lenses, Other instructions may be given by the doctor if necessary. All new contact lens wearers must be instructed on how to insert, remove, handle, and take care of contact lenses, and be able to demonstrate these skills in the office before any contact lenses can be dispensed. New contact lens wearers or those who have not worn contact lenses for a while should start by wearing the lenses on a gradual schedule (2-4 hours the first day, then add 2 hours a day for a maximum of 12 hours per day). Before approving that contact lens wear is safe for the patient to continue or begin, and in order to determine the appropriate contact lens type and instructions, the doctor must review the patient's history and evaluate the refractive status, corneal curvature, specific aspects of ocular health, and other factors. Due to this increase in the required level of professional judgment, and the additional liability that comes with it, there is a "contact lens patient evaluation fee". This fee may be due at the time of the exam regardless of whether insurance is being filed. "Evaluation" fees are higher for specialty contact lens fits such as toric, monovision, multifocal, and RGP. Approval to try contact lenses is not a guarantee that the fit will be successful and/or the patient will be a good candidate for contact lens wear, therefore trial periods and/or follow-up visits may be required before a final decision is made. The fee for related follow up visits and necessary trial lenses is included in original "evaluation" fee. Returning for follow up visits more than 45 days after the exam and/or later than dates instructed by the doctor may result in extra fees such as a new evaluation fee and/or shipping and handling fees for new trial lenses. Once the fit is deemed successful by the doctor, a final contact lens prescription will be released and valid for one year from the exam date. By signing below, I authorize for the patient to be fitted in contact lenses under said terms:

PATIENT NAME _______________ DATE OF BIRTH ___/___/___

PATIENT SIGNATURE *(Or guardian/caregiver if applicable)* _______________ PRINTED NAME OF SIGNATORY _______________ TODAY'S DATE ___/___/___