OPTX OPTOMETRY

EMAIL Print

NAME: _____ DOB: _____ AGE: _____ DATE: _____
ADDRESS: _____ LAST 4 SSN: _____ OCCUPATION: _____
CITY/STATE/ZIP: _____ EMAIL: _____
PHONE: _____ HOW DID YOU HEAR ABOUT US: _____
MEDICAL DOCTOR: _____ PHONE: _____
EMERGENCY NAME: _____ PHONE: _____
INSURANCE SUBSCRIBER NAME: _____ DOB: _____ LAST 4 SSN: _____

EYE & MEDICAL HISTORY

MEDICATIONS: _____
ALLERGIES TO MEDICATIONS: ○ YES _____ ○ NO
PREGNANT/NURSING: ○ YES ○ NO ○ N/A TOBACCO: ○ YES ○ NO ALCOHOL: ○ YES ○ NO DRUGS: ○ YES ○ NO
HAVE YOU BEEN EXPOSED TO OR INFECTED WITH: ☐ GONORRHEA ☐ SYPHILIS ☐ HIV/AIDS ☐ HEPATITIS
LAST EYE EXAM: _____ GLASSES: ○ YES ○ NO IF YES, HOW OLD ARE THEY: _____
CONTACTS: ○ YES ○ No TYPE: _____

	SELF	FAMILY		SELF	FAMILY		SELF	
Cataract	☐	☐	Diabetes (Type 1 / 2)	☐	☐	Shingles	☐	
Glaucoma	☐	☐	Kidney Disease	☐	☐	Asthma	☐	
Macular Degeneration	☐	☐	Thyroid Dysfunction	☐	☐	COPD/Emphysema	☐	
Color Blindness	☐	☐	Brain Tumor	☐	☐	Sleep Apnea	☐	
Amblyopia	☐	☐	Migraine Headaches	☐	☐	Epilepsy/Seizure	☐	
Strabismus	☐	☐	Anemia	☐	☐	Depression	☐	
Diabetic Retinopathy	☐	☐	Allergies	☐	☐	Anxiety	☐	
Keratoconus	☐	☐	Multiple Sclerosis	☐	☐	Bipolar	☐	
Retinal Detachment	☐	☐	Rheumatoid Arthritis	☐	☐	ADD/ADHD	☐	
Retinitis Pigmentosa	☐	☐	Lupus	☐	☐	Eczema	☐	
Hypertension	☐	☐	Sjogren's Syndrome	☐	☐	Rosacea	☐	
Cholesterol	☐	☐	Ulcerative Colitis	☐	☐	Psoriasis	☐	
Heart Disease	☐	☐	Crohn's Disease	☐	☐	Gout	☐	
Stroke	☐	☐	Ankylosing Spondylitis	☐	☐	Developmental Disability	☐	
Cancer	☐	☐	Scleroderma	☐	☐	Other:	☐	☐

Acknowledgement of Receipt of Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at OPTX OPTOMETRY, we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls.

_____

SIGNATURE **DATE**

PLEASE TURN OVER AND COMPLETE OTHER SIDE

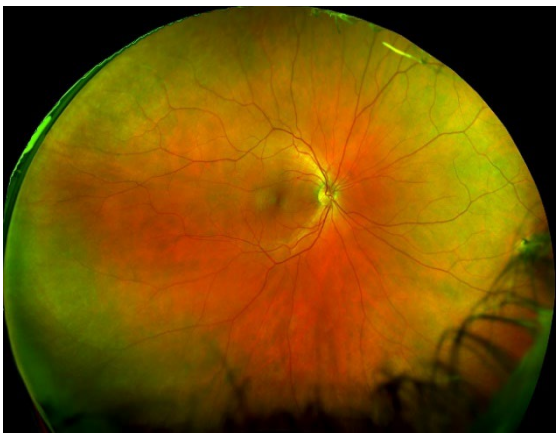
ADVANCED RETINAL IMAGING

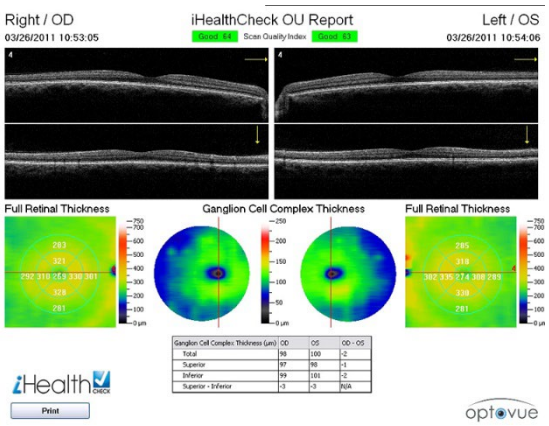
Optomap Retinal Exam:

- ✓ Is as fast as taking a picture.
- ✓ Can detect and monitor conditions such as macular degeneration, glaucoma, retinal holes or detachments, hypertension, diabetes, cancer/tumors and autoimmune disorders.
- ✓ Does not require dilating drops. You may not need to be dilated today, potentially avoiding side effects such as blurry vision and light sensitivity.
- ✓ Will be saved in your file enabling your optometrist to make important comparisons during your annual eye exam.
- ✓ Is recommended for all patients every year.

Optovue *iWellness* Exam:

- ✓ Is a quick scan.
- ✓ Allows the optometrist to see beneath the surface of your retina.
- ✓ Helps detect vision threatening and systemic diseases which have no outward signs or symptoms in the early stages.
- ✓ Is recommended for all patients every year.





☐ **Imaging Package A - $59 for both Optomap and Optovue exams** (normally $78). Imaging performed once annually.

☐ **Imaging Package B - $110/year pre-pay** (normally $156). Imaging performed twice annually. Offers better eye health monitoring. Includes glasses deep cleaning and adjusting at no charge and get 15% off new frames.

DILATION

Dilation is the enlargement of the pupils using special eye drops. This procedure allows the doctor to observe the internal eye more completely to rule out conditions such as glaucoma, retinal detachments, cataracts, eye tumors, and other sight or life-threatening conditions. Because dilations cause blurred vision and light sensitivity for about 4-6 hours, it is best to have a driver after the test. Disposable sunglasses might be provided to reduce light sensitivity. Please consult the front desk if there are any questions.

◯ **YES**, I give permission to the doctor to perform dilation today.

◯ **NO**, I choose not to have dilation done. I understand that an exam of the retina through a dilated pupil is necessary to detect conditions that would otherwise be unobservable. These conditions, if undetected, may lead to partial or total vision loss.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such eye care to third party payers and /or health practitioners. I authorize my insurance company to pay directly to **OPTX OPTOMETRY**. I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductible and fees not paid by my insurance carrier will be my responsibility. I also understand that there will be no refunds for rendered professional medical services related to eye exams or contact lens fitting or evaluations.

SIGNATURE **DATE** EMAIL Print