Optic Gallery

Date _____ Please Print First Visit (Y/N) _____

Patient's Name _____ Sex (M/F) ____ Age _____ Date of Birth ____/____/____

Social Security # _____-_____-_____ Email Address _____

If Married, Spouse's Name_____ Spouse's S.S # _____-_____-_____ Spouse's D.O.B _____/_____/____

If Child, Parent's Name _____ Parent's S.S # _____-_____-_____ Parent's D.O.B _____/_____/____

Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Business Phone _____

Place of Employment/School _____ Occupation _____

Does your work require special vision needs? _____ If yes, please explain _____

Primary Insurance _____ Primary Insurance # _____ Vision Care Plan _____

Date of Last Exam _____ Where _____ Doctor _____

Do you wear contact lenses? □ Yes □ No Type _____ Are you interested in wearing contact lenses? □ Yes □ No

Reason for Today's Visit _____

List Activities/Hobbies _____

How were you referred to our office? _____

MEDICAL HISTORY:

Medical Doctor _____ Last Visit _____

Do you have? □ **I Have No Medical Conditions** Do you: □ Smoke □ Drink □ Use Drugs

□ Heart Disease □ Asthma □ Major Illness **Medications: □ None** _____

□ Diabetes □ Lung Disease □ Pregnant/Nursing _____

□ High Blood Pressure □ Cancer □ Surgery _____ _____

□ High Cholesterol □ Kidney Disease _____ **Allergies: □ None** _____

□ Thyroid Problems □ Sinus Problems □ Other _____ _____

□ Headaches □ Allergies _____ _____

Does Anyone in Your Family Have? □ **I Have No Family History of Medical Conditions**

□ Diabetes □ Cancer □ High Blood Pressure

□ Heart Disease □ Lung Disease □ Other _____

OCULAR HISTORY:

Do you have? □ **I Have No Ocular Conditions**

□ Glaucoma □ Blurred Vision □ Eye Itching □ Eye Fatigue

□ Cataracts □ Double Vision □ Eye Watering □ Eye Turn or Lazy Eye

□ Macular Degen. □ Flashes □ Eye Redness □ Eye Surgery (LASIK, PRK, etc.) _____

□ Blindness □ Floaters □ Eye Trauma □ Other Eye Disease _____

Does Anyone in Your Family Have? □ **I Have No Family History of Ocular Conditions**

□ Glaucoma □ Blindness □ Macular Degen. □ Eye Disease □ Other_____

In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, I authorize Optic Gallery, and/or any of their associates to release and/or request these records. If applicable, I request that payment of authorized Medicare or other insurance be made either to me or on my behalf to Optic Gallery, and/or any of their associates for any services rendered to me. I authorize pertinent medical information about me to determine insurance benefits and billing to be released to the health care financing or other insurance agencies.

I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.

It is the policy of this office to require:

1) Payment in full or at least one-half before the order can be placed.
2) The balance of the fee must be paid at the time the order is dispensed.
3) All orders are final when placed.

SIGNATURE (Patient or Guardian):_____ **DATE**_____

WE THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM AND FOR CHOOSING OPTIC GALLERY FOR YOUR VISION CARE.

Optic Gallery

Patient's Name _____ Date _____

Dilation of the Eyes

It will be necessary to dilate your pupils in order to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the back of your eyes. The dilating drops typically last 3-4 hours. During this time you may find it difficult to focus at near, and less commonly at distance. You may be sensitive to light. You will be provided with post-dilation sunglasses. We strongly recommend caution when driving or operating equipment or machinery after dilation. If you feel you would not be able to drive or return to work, we can reschedule the dilation portion of your exam. Signing in this section signifies that you have been informed of the risks and benefits of dilation.

Please select one of the options below, indicating your choice for dilation:

□ I wish to have my eyes dilated today.

□ I do not wish to have my eyes dilated and assume the responsibility of having an eye exam without dilation.

□ I wish to have a dilation scheduled for another day

Signature (Patient or Guardian) _____ **Date** _____

Acknowledgement Notice of Privacy Practices

Signing in this section signifies that you have received a copy of our *Notice of Privacy Practices*

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for these services, and to conduct healthcare operations involving our offices. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

Record Retention Policy

We are informing you that our office will keep your records for 5 years from the date of this examination. If signing for a minor, please be aware that our office will only keep your child's records for 5 years from the date of this examination.

Signature (Patient or Guardian) _____ **Date** _____