# Optic Gallery

Please Print

Date _____ First Visit (Y/N) _____

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

Social Security # ___-___-___ Email Address _____

Insured's Name _____ Insured's S.S # ___-___-___ Insured's D.O.B ___/___/___

Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Business Phone _____

Place of Employment _____ 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 (Past or Present)? □ **I Have No Medical Conditions**

□ Heart Disease □ Asthma □ Major Illness

□ Diabetes □ Lung Disease □ Surgery _____

□ High Blood Pressure □ Cancer _____

□ High Cholesterol □ Kidney Disease □ Other _____

□ Thyroid Problems □ Sinus Problems _____

□ Headaches □ Allergies _____

Do you: □ Smoke □ Drink □ Use Drugs

Medications: □ None _____

_____

_____

Allergies: □ None _____

_____

_____

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 (Past or Present)? □ **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, Dr. Chen Young 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, Dr. Chen Young 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 Boca Park

## Patient Privacy Notice Summary:

Earning and maintaining your trust and safeguarding your privacy is the cornerstone of our patient relationship with you. The protection of your privacy is a key part of maintaining your trust. This has been a fundamental operating principal of Optic Gallery Boca Park since our founding and remains so today. This Patient Privacy Notice Summary lets you know we maintain strict internal policies regarding confidentiality of patient information. We maintain physical, electronic, and procedural safeguards that comply with federal guidelines to safeguard patient information. Our employees are bound by our policies to access patient information only for legitimate clinical and/or business purposes and to keep such information confidential at all times. We pledge to do all we can to protect your privacy. If you have any questions about our privacy policy, or about how our information is maintained, safeguarded, or used, please contact our privacy officer, Trudie Lee, at (702) 938-2020. Signing this section signifies you have received a copy of our Notice of Privacy Practices.

Signature (Patient or Guardian) _____ Date _____

## Medical Services Contract:

I hereby authorize and consent to medical treatment by Optic Gallery Boca Park for me (or my child). I authorize Optic Gallery Boca Park to release my (or my child's) family doctor and to any insurance company, adjuster, attorney, authorized agent working on behalf of Optic Gallery Boca Park or other authorized party. I understand that I am responsible for payment of all vision and medical treatment rendered to me (or my child) by Optic Gallery Boca Park and I agree to pay all co-payments, deductibles, and non-covered services in full at the time of the visit. I understand that, as a courtesy to me, Optic Gallery Boca Park will file a claim with my (or my child's) insurance carrier, and I authorize payment directly to Optic Gallery Boca Park for the benefits otherwise payable to me under the terms of my (or my child's) insurance. I understand that I am responsible for maintaining current coverage information to meet filing deadlines and for the payment of any remaining balance after payment from my insurance carrier.

Signature (Patient or Guardian) _____ Date _____

## Dilation of the Eyes:

In order to perform a thorough and complete ocular exam, it will be necessary for us to dilate your pupils. Dilation allows the Doctors at Optic Gallery Boca Park to obtain a better view of the back of the eyes. Many medications, vitamins, and foods can influence the health of your eyes and your vision. Diseases such as high blood pressure, diabetes, arthritis, auto-immune disorders and many other conditions can affect ocular health and vision. Dilation specifically allows us to examine the optic nerve, blood vessels, macula and the extreme edges of the retina to ensure that no problems exist that could potentially lead to vision loss. Side effects of dilation include blurry vision up close for 4-06 hours and light sensitivity. We strongly recommend caution when driving or operating equipment or machinery after dilation. Signing below signifies you have been informed of the risks and benefits of dilation. Please select one of the options below:

- o I wish to have my eyes dilated
- o I do not wish to have my eyes dilated and I assume the responsibility of having an eye exam without dilation
- o I wish to discuss dilation with the doctor

Signature (Patient or Guardian) _____ Date _____

# Optic Gallery

## Eye Wellness/Preventative Care

### OCT Retinal Scan/Digital Retinal Photography

Sight threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms. That is why eye exams, including a thorough retina evaluation, are important to protect vision. In an effort to provide a more advanced comprehensive eye exam, Optic Gallery has incorporated the Wellness Exam OCT retinal scan and Digital Retinal Photography as part of your eye exam today.

Our technician will perform these two tests before you go into the exam room and the Doctor will review these with you during your examination today. These two tests will become part of your permanent patient record. The $49 charge is typically not covered by your medical or vision insurance. This cost will be added into the price of your visit today. Any questions you have about these tests can be discussed during your examination with your Doctor.

- **Diabetes**
- **Cataracts**
- **High Blood Pressure**
- **Frequent or Severe Headaches**
- **High Nearsightedness**
- **Symptoms of Flashes or Floaters**
- **Personal or family History of Glaucoma**
- **Over the age of 40**

**Please check one:**

____ **I wish to have the OCT Retinal Scan/DRP done today.**

____ **I do not wish to have the OCT Retinal Scan/DRP done today.**

____ **I wish to have the OCT Retinal Scan/DRP scheduled for another day.**

____ **I wish to discuss the OCT Retinal Scan/DRP (Preventative Care) with the Doctor.**

**Signature :** _____ **Date:** _____ **:**

If patient is a minor (under 18 years old), parent must sign this.