OPTIC GALLERY

Today's Date _____/_____/_____

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

Married **(Y/N)** ___ **Name of Insured** _____ **Insured's S.S.#** _____-_____-_____

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

Address _____ City _____ State _____ Zip _____

Phone _____-_____-_____ Cell _____-_____-_____ Business Phone _____-_____-_____

Place of Employment/School _____ Occupation _____

Medical Insurance _____ **Member ID** _____ **Patient's Email** _____

Vision Insurance _____ Secondary Vision Insurance _____

List Activities/Hobbies _____

Date of Last Eye examination: _____/_____/_____ Where _____ Doctor _____

Do you wear contact lenses? **(Y/N)** ___ Type _____ Are you interested in wearing contact lenses? **(Y/N)** ___

Reason for Today's visit: _____

How were you referred to our office? _____

MEDICAL HISTORY:

Medical Doctor _____ Last visit _____ Phone _____-_____-_____

Do you have (Past or Present)?

___Heart Disease ___Diabetes ___Major Illness
___Hypertension ___Lung Disease ___Surgery
___Kidney Problems ___Cancer ___Sickle Cell
___Ulcers ___Asthma ___Cholesterol
___Thyroid Problems ___Sinus Problems ___Other
___Headaches ___Allergies

Do you: Smoke ___ Drink ___ Use Drugs__

Medications: _____
_____
_____
_____

Does anyone in your family have?

___Diabetes ___Cancer ___Hypertension
___Heart Disease ___Lung Disease ___Other

Allergies: _____
_____

OCULAR HISTORY:

Do you have (Past or Present)?

___Glaucoma ___Blurred Vision ___Flashes ___ Watering ___Trauma
___Cataracts ___Double Vision ___Eye Fatigue ___Redness ___Surgery
___Blindness ___Floaters ___Itch ___Eye Turn ___Dry Eye

Does anyone in your family have?

___Glaucoma ___Blindness ___Macular Degeneration ___Eye Disease ___Other

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 RENDERRED 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 INSURANCE COMPANY.

In the event that it becomes necessary for Optic Gallery to release and/or request your records from another healthcare professional, your written permission is required.
I authorize Optic Gallery, Dr. Chen Young or any of their associates to release and/or request these records.

PATIENT SIGNATURE (Patient or Guardian): _____

It is policy of this office to require:

1. Payment in full or at least one-half before the order can be placed.
2. All balances that are left on the account must be paid in full upon patient/ guardian pick up.
3. **All orders are final when placed.**

PATIENT SIGNATURE (Patient or Guardian): _____ **DATE:** ____/____/_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM AND FOR CHOOSING OUR OFFICE FOR YOUR EYECARE AND VISION NEEDS

OPTIC GALLERY

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 (PPI) 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 that you have read and received a copy of our Notice of Privacy Practices.

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

Signature of Patient/ Guardian _____ **Date** _____/_____/_____

Consent for 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 eye. 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 our ocular health and vision. Dilation specifically allows us to examine the Optic Nerve, Blood Vessels, Macula and extreme edges of the retina to ensure that no problems exist that could potentially lead to permenant vision loss. Side effects of dilation include blurry near vision for approximately 4-6 hours, and light sensitivity. Our Doctors strongly recommend caution when driving or operating equiptment 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:

- I wish to have my eyes Dilated today _____
- I do not wish to have my eyes Dilated and I assume the responsibility of having an eye exam without Dilation _____
- I wish to discuss Dilation with the doctor before making a decision _____

Signature of Patient/ Guardian _____ **Date** _____/_____/_____