WELCOME TO OUR OFFICE

Name ______________________________ **Date of Birth:**___/___/___

If minor, Parents or Legal Guardian ______________________________

Mailing Address ______________________ **City** ____________**Zip Code**________

Primary Phone: ________________ **Alternate:**________________ **Texting: YES/NO**

Email:______________________________

Employer: ______________________ **Occupation:** ______________________

Insurance: ____________________ **Primary Care Physician:** ____________________

Current Health History (please check if YES)

☐ **Dry Eyes**	☐ Asthma	☐ Heart Condition	☐ Seizures
☐ Allergies	☐ Diabetes	☐ High Blood Pressure	☐ Thyroid Condition
☐ Arthritis	☐ Headache	☐ Pregnancy	☐ Other:

Present Medication & Supplements: (including birth control pills)

____

Medication Allergies:

____

FAMILY HISTORY (Please check if YES)

☐ Cataracts	☐ Keratoconus	☐ Macular Degeneration
☐ Glaucoma	☐ Lazy Eye	☐ Retinal Detachment

Primary reason for today's visit?______________________________

Date of last eye exam: ________________ **Date of last physical exam:** ________________

Do you presently wear glasses?	☐YES	☐NO	**Are you interested in contact lenses?**	☐YES	☐NO
Do you presently wear contacts?	☐YES	☐NO	**Are you interested in LASIK?**	☐YES	☐NO

Fees for professional services are due on the day of service. Fees not covered by insurance are the responsibility of the patient.

I have read and understand the above policy:

______________________________ ________________

Signature of Patient or Guardian ***Date***

WELCOME TO OUR OFFICE

THE FOLLOWING INFORMATION MUST BE REVIEWED BY EACH PATIENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OLD

I authorize the doctor and staff to administer such treatment as reasonable or necessary in connection with the condition for which I or members of my family have sought care for.

I authorize the doctor and staff to disclose my health information to any health care provider for the purpose of rendering treatment to me.

I authorize the doctor and staff to disclose my health information to any health insurance company that provides insurance coverage for me for the purpose of payment of charges.

IF PATIENT WILL BE FIT FOR CONTACT LENSES

I understand that the contact lens service fee is a non-refundable service charge whether the fit is successful or not.

I understand that the contact lens service fee includes up to three contact lens follow-up visits (if needed) performed within three months of the initial contact lens consultation.

I understand that the prescribing doctor will release my contact lens prescription once I have returned for all necessary follow-up appointments. The contact lens prescription will be valid for one year from the date of the original examination.

I understand that the contact lens service fee does not include services provided to treat eye infections, abrasions, trauma or any other medical condition incurred while using contact lenses whether they can be attributed to actual contact lens use or not. Treatment of other medical conditions will be billed to my medical insurance when applicable. If I do not have any medical insurance, I will be responsible for the charges incurred.

HIPAA ACKNOWLEDGEMENT

I acknowledge I have received the HIPAA privacy policy and a copy has been made available to me.

I have read and understand the above policies:

____ ________________

Signature of Patient or Guardian ***Date***

For office Use: ***O____*** ***M____*** ***V____***