## Thank you for choosing ONE HOUR OPTICAL for your eye care needs!

[Patient] Mr. Mrs. Ms. Dr. _____ _____ _____ _____

**Last Name** **First Name** **M.I.** **Preferred Name**

Birth Date ___/ ___/ ___ Age _____ Sex: M or F SS# _____ Grade/Occupation _____

Address _____ Apt # _____ Preferred Phone (_____) _____

City _____ State _____ Zip Code _____ Alternate Phone (_____) _____

Email address _____

*Person responsible for the bill:*

Name _____ Relationship to Patient _____ Birth Date ___/ ___/ ___ SS# _____

Address if different [Address/P.O. Box, City, ST Zip] _____Phone (_____) _____

**Please present your current insurance card(s) to the front desk in order for us to update our records.**

*Primary* Health Insurance Company _____ Subscriber Name _____

DOB ___/ ___/___ Subscriber ID# _____ Group No. _____ Employer _____

Insurance address _____ City _____ State _____ Phone number (_____) _____

*Secondary* Health Insurance Company _____ Subscriber Name _____

DOB ___/ ___/___ Subscriber ID# _____ Group No. _____ Employer _____

Insurance address _____ City _____ State _____ Phone number (_____) _____

*Vision Insurance Company:* VSP / Spectera / Davis / EyeMed / Denver Health, etc. _____

Subscriber Name _____ Subscriber ID# _____ DOB _____/ _____/_____

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What concerns bring you in for an eye examination today?

_____

When was your last eye exam? _____ What office? _____ Were you dilated? Y N

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### HIPAA Notice

_____ ***(Initials)*** I acknowledge that I can request a copy of One Hour Optical's Notice of Privacy Practices (available from our office front desk). The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

### Notice to Contact Lens Patients

_____ ***(Initials)*** The contact lens fitting/evaluation fee provides you with the diagnostic contact lenses needed for your prescription to be finalized. All follow-up appointments related to your contact lenses (up to three months) are included in this fee. Professional service fees, including the examination charges and contact lens fitting fee, are non-refundable. Per federal law, contact lens prescriptions expire one year from the date of the fitting.

### Insurance Billing Release

_____ ***(Initials)*** I authorize the exchange of information necessary for treatment, payment and healthcare operations, including the processing of insurance claims. I understand that I may have co-payments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred. One Hour Optical does not guarantee the accuracy of benefit information given to us from insurance companies. If you have questions about your coverage, please contact your insurance representative.

**CHOOSE ONLY ONE OF THE FOLLOWING:**

### Optomap Retinal Imaging

**_____ Accept _____ Decline** ***(Please check one)*** Our Doctor is concerned about retinal problems including melanoma, macular degeneration, glaucoma, retinal holes, retinal detachments and systemic diseases such as diabetes, stroke and high blood pressure. These conditions can lead to serious health problems including partial loss of vision or blindness and often develop without warning and progress with no symptoms. The Optomap retinal exam takes an ultra-widefield retinal photo of up to 200 degrees of the inside of your eye which then becomes a permanent part of your medical record and can aid in diagnosing disease sooner. This photo can be compared to future photos which will reveal even small changes in the health of the eye. In most instances this is not covered by insurance, therefore **a $35 copay will apply.** *Optomap is recommended by your doctor.*

### Pupil Dilation Consent/Release

**_____ Accept _____ Decline** ***(Please check one)*** Pupil dilation is performed as an alternative to Optomap Retinal Imaging to view the periphery of the eye as part of a comprehensive health examination. An eye drop is used to enlarge the pupil. You will be sensitive to light and may have blurry near vision for about 4-6 hours. People usually have no problems driving after pupil dilation.

**CONTINUED ON THE BACKSIDE**

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**Health Conditions Questions**

Do you have any allergies to medications? Y / N If yes, please list: _____

Do you take any medications? Y / N (**include over-the-counter medication**):

_____

Do you or your Family Members have any of the following conditions?

*P =Patient has this problem F = Family member has this problem*

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Lazy eye | P | F | Glaucoma | P | F | Macular Degeneration | P | F | Diabetes | P | F |
| Eye Surgery | P | F | Cataract | P | F | Retinal Detachment | P | F | High Cholesterol | P | F |
| Blindness | P | F | Cancer | P | F | Color Blindness | P | F | High Blood Pressure | P | F |

Do **YOU** have problems in the following areas or do you have a history of problems in the following areas:

(Please Circle all that apply):

| | | | | |
|---|---|---|---|---|
| Fever | Allergies/Hay Fever | Genitourinary Problems | Multiple Sclerosis | |
| Weight Loss/Gain | Sinus Congestion | Psychiatric | Lupus | |
| Skin Conditions | Chronic Cough | Gastrointestinal Problems | **EYE CONDITIONS** | |
| Discharge | Asthma | Muscle/Joint Pain | Burning | Flashes |
| Headaches | Chronic Bronchitis | Abnormal Bleeding | Itching | Floaters |
| Migraines | Emphysema | Anemia | Redness | Sties or Chalazion |
| Seizures | Heart Pain | Rheumatoid Arthritis | Dryness | Double Vision |
| Thyroid/Other Glands | Vascular Disease | | Tearing | Blurry Vision |

Other Health Problems, Surgeries, or Hospitalizations you have had:

_____

**Social History** (This information is kept strictly confidential; however, you may discuss this portion directly with the doctor if you prefer.)

❑Yes, I would prefer to discuss my Social History information directly with my doctor

Do you use Tobacco products? Y N If yes, type/amount/how long? _____ Do you drink alcohol? Y N

Do you use illegal drugs? Y N Have you been infected with: ❑ HIV ❑Gonorrhea ❑Hepatitis

| | | | |
|---|---|---|---|
| Are you currently pregnant or nursing? | Y N | Are you interested in LASIK? | Y N |
| Do you currently wear contact lenses | Y N | Do you want contact lenses today? | Y N |

**Patient Signature or Parent/Legal Guardian if patient is a minor: _____ Date: _____**