All EyeCare Optometry New Patient Intake Form

Last:_____First:_____MI_____

Address:_____

_____

Tel:(___)_____Email:_____

Date of Birth:_____Age:_____Sex: M F

Ocular History:

Purpose of today's visit:

- ❑ Annual Visit
- ❑ Blurry Vision
- ❑ Burning
- ❑ Double vision
- ❑ Dryness
- ❑ Flash of light
- ❑ Floaters/spots in vision
- ❑ Grittiness
- ❑ Headaches
- ❑ Infection
- ❑ Itchiness
- ❑ Night vision difficulty
- ❑ Eye pain
- ❑ Tearing
- ❑ Update contact lenses

When was your last eye exam? _____

Do you wear contact lenses? Y N

Have **you** been diagnosed with the following?

- ❑ Cataracts
- ❑ Corneal abrasion
- ❑ Dry Eye
- ❑ Eye turn
- ❑ Glaucoma
- ❑ Injury
- ❑ Iritis/uveitis
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal defect/hole/tear
- ❑ Retinal detachment
- ❑ Other eye diseases

Has anyone in your **family** been diagnosed with the following?

- ❑ Cataracts
- ❑ Eye turn
- ❑ Glaucoma
- ❑ Iritis/uveitis
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal detachment
- ❑ Other eye diseases

Circle Your Vision Insurance:

VSP EyeMed MES SafeGuard TriCare None

Medical Insurance Information

Medical Insurance:_____PPO/HMO/IPA

Member ID:_____

Group _____

Policy Holder's Name if different_____

Policy Holder DOB:___/___/___ **SSN:**_____

Relationship to Patient:_____

Visual Needs Assessment:

Hours of computer usage per day:_____

Hours of outdoor activity per day:_____

Hobbies:_____

_____

Sports:_____

How many hours do you read before you experience fatigue?____

Circle if you have: eyestrain neck strain headaches

Who can we thank for your referral to our office?

_____

Current Medications and Dose (include OTC and supplements)

_____

_____

_____

_____

_____

Allergies: _____

_____

List any prior surgeries and dates if known:

_____

_____

Do you use cigarettes? Y N **If so, how often?**_____

Do you drink alcohol? Y N **If so, how often?**_____

Medical History:

Have you ever been diagnosed or treated for any of the following health problems?(If yes include diagnosis; otherwise, circle N for No and F for family history)

Allergies	Y_____	N	F
Arthritis	Y_____	N	F
Blood/Lymph	Y_____	N	F
Cancer	Y_____	N	F
Cholesterol	Y_____	N	F
Diabetes	Y, Type_____	N	F
Digestive/Gastric	Y_____	N	F
Ears/Nose/Throat	Y_____	N	F
Endocrine	Y_____	N	F
Fatigue	Y_____	N	F
Fevers	Y_____	N	F
Heart Disease	Y_____	N	F
High Blood Pressure	Y_____	N	F
Immune	Y_____	N	F
Integumentary (Skin disease)	Y_____	N	F
Kidney	Y_____	N	F
Muscle or Bone	Y_____	N	F
Neurological/Headaches	Y_____	N	F
Psychological	Y_____	N	F
Respiratory	Y_____	N	F
Sinus	Y_____	N	F
Stroke/Seizures	Y_____	N	F
Throat Infections	Y_____	N	F
Thyroid	Y_____	N	F
Unusual Weight Loss/Gain	Y_____	N	F

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- ✓ A statement that this practice is required by law to maintain the privacy of protected health information.
- ✓ A statement that this practice is required to abide by the terms of the notice currently in effect.
- ✓ Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and health care operations
- ✓ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- ✓ A description of uses and disclosures that are prohibited or materially limited by law.
- ✓ A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- ✓ I received notification that the members at All Eyecare Optometry will have access to my claims medication history through an electronic service until I revoke my consent. I understand that my consent can be revoked at any time. Revocation must be made in writing.
- ✓ My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of Health and Human Services (HHS) if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information
    - The right to amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient: Name: _____ Date of Birth:_____

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient):_____

Payment Policy:

I hereby assign all medical benefits, including all major medical benefits to which I am entitled including Medicare, private insurance and any other health plans, to All EyeCare Optometry. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed All EyeCare within 60 days, I may be billed for any services or products that I have received. I certify that my responses on this form are accurate to the best of my knowledge. I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. ***I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs.***

Signature:_____Date:_____

Optomap Digital Eye Imaging Technology

All EyeCare Optometry is pleased to offer you and your family the most highly advanced technology available in eye disease detection, the Optomap Digital Retinal Imaging System.

Our Doctors are concerned about retinal diseases such as macular degeneration, glaucoma, retinal detachments, and diabetic retinopathy, all which can lead to partial loss of vision or blindness. Additionally, systemic diseases such as diabetes and high blood pressure can be detected with a retinal examination. Eye exams with retinal evaluations can help you safeguard both your eyesight and general health.

The Optomap Digital Retinal Imaging System allows us to scan 85% of the retina to thoroughly to evaluate your internal eye health with dramatically improved precision.

The doctor strongly recommends that all patients have this procedure performed annually. It is especially important for people who have:

- **Headaches**
- **Diabetes**
- **High Blood Pressure**
- **High Cholesterol**
- **Family history of glaucoma, blindness, or macular degeneration**
- **Family history of diabetes or high blood pressure**

With an annual Optomap, our doctors can track your eye health for concerns, perform annual comparisons, and initiate treatments sooner. Medical and Vision insurances do not pay for *routine* photos. As a result, there is a **$35.00** fee for this procedure. *(Please advise staff if you have a history of epilepsy.)*

The Optomap augments a dilated exam by creating a permanent documentation of the retina.

_____ I elect to have an Optomap Digital Retinal Scan of my retina and understand the scan will provide a permanent baseline comparison for my future visits. I understand that based on the doctor's assessment of the retinal scan and examination a dilation may still be recommended.

_____ **I DECLINE** the Optomap Retinal Scan and am choosing to only be dilated today. I understand that my vision will be slightly blurry when reading after dilation and light sensitive for 3-4 hours.

_____ **I DECLINE** BOTH the Optomap and dilation. I understand that the potential for partial or total loss of vision may exist due to undetected eye disease. I therefore release Dr. Mann Trinh and associates from any liability resulting from failure to diagnose or treat any eye condition due to the lack of diagnostic information, which could have been obtained by performing these tests.

Print Name: _____Signature: _____Date:_____

Patient's Parent or Guardian if patient is a minor

CONTACT LENS CARE AGREEMENT:

Contact lenses are FDA class I medical devices that have the potential for serious complications if not used and fitted properly. For that reason, the standard of care and the requirements of the California State Board of Optometry require an annual examination for renewal of a contact lens prescription. In addition to general eye health assessment, the doctor will assess issues related to contacts such as abnormal blood vessel growth, corneal damage, chronic inflammation, hygiene, discomfort, and poor surface compatibility, in addition to any vision changes. The ***estimated fee*** for these services range ***between $55.00 and $125.00***. These fees will cover any contact lens related follow ups for a 30 day period. If you cannot complete the fitting procedure in the allotted time due to missed follow up appointments, there will be an additional $25.00 charge per visit beyond the global time period. Additional fees for ***training for insertion and removal*** of contact lenses range between ***$40.00 and $60.00*** and apply to all new wearers.

By signing, I acknowledge that I understand the policies regarding the fitting of contact lenses and agree to the associated fees. I understand that these fees are an estimate and are subject to changes based on the doctor's final assessment. I also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage. I understand that if an infection is present, I will need to be treated under my medical insurance prior to being refit with contact lenses.

Signature:_____ **Date:**_____

CONTACT LENS QUESTIONNAIRE:

Basic - Spherical / Intermediate - Astigmatism / Complex - Multifocal, High Rx

Specifications: Brand of Contacts:_____ Solution Name:_____

Vision:

Can you see distance and near comfortably with your contact lenses? **Yes** **No**

Life Style:

How many days a week do you wear your contact lenses? _____days / week

How many hours a day do you wear your contact lenses? _____hours / day

If you store your lenses in solution, do you discard your solution every morning? **Yes** **No**

Do you sleep overnight in your contact lenses? **Yes** **No**

If you sleep in your contacts, for how many nights? _____nights

Do you swim in your contact lenses? **Yes** **No**

Do you shower in your contact lenses? **Yes** **No**

Comfort:

Do you experience dryness with your contact lenses? **Yes** **No**

Do you have difficulty with seasonal allergies? **Yes** **No**

Contact Lens Health History

Have you had a contact lens related eye infection or complication? **Yes** **No**

If yes, please explain: _____

Have your eyes become contact lens intolerant over the years? **Yes** **No**

Hygiene:

Do you have a backup pair of glasses? **Yes** **No**

Do you rub your contact lenses with solution when cleaning? **Yes** **No**

How often do you change your contact lens case? _____

How often do you change your contact lenses? _____

Please rank from most important to least important so that the doctor can prescribe to enhance your contact lens experience

(1 – Most important, 4- Least important): ____ Convenience ____Comfort ____ Clarity ____ Cost

How can we improve your experience with your contact lenses? _____

_____