Date:_____ (please print)

OPTIC GALLERY
Family Eye Care

PATIENT INFORMATION

Patient Name_____ Sex (M/F/non-binary) _____ DOB_____/_____/_____ Age _____

Address_____City_____State_____Zip_____

Nickname _____ Marital Status _____ Employment status _____

Primary Phone #_____(Home/work/cell) Employer/school_____

Alternate phone#_____(Home/work/cell) Occupation/grade_____

Social Security# _____-_____-_____ Email address:_____

INSURED INFORMATION

Insured's Name_____ Insured SSN_____ Insured DOB _____

Vision Insurance/ID # _____ Medical Insurance/ ID#_____

VISIT INFORMATION

Reason for today's visit _____

Last Eye Exam _____ Drs Name _____ Last Physical _____ Drs Name_____

List Activities & Hobbies _____

Does your work require any special vision needs? _____ Do you wear Sunglasses?_____

Do you wear contact lenses? Y / N Brand _____ If not, Interested in contacts?_____

How did you hear about our office? (include name if referred)_____

OCULAR HISTORY ☐ I have No Ocular Symptoms Ocular Surgeries_____Date_____
(Check all that apply): (Specify eye)

☐ Dryness ☐ Watery Eyes ☐ Retinal Detachment
☐ Itchiness ☐ Eye fatigue ☐ Flashes and/or Floaters
☐ Blurred Vision ☐ Eye redness ☐ Cataracts
☐ Blindness (cause)_____ ☐ Double Vision ☐ Macular Degeneration
☐ Eye Trauma (cause)_____ ☐ Lazy Eye/crossed eyes ☐ Glaucoma

MEDICAL HISTORY ☐ I Have No Medical Conditions Recent Hospitalization (date/reason)_____
(Check all that apply):

☐ Diabetes - Year Diagnosed:_____ A1c: ____ ☐ Allergies ☐ Sinusitis ☐ Blood Disorder
☐ Hypertension ☐ Asthma ☐ Kidney Disease ☐ Cancer (type)_____
☐ Elevated Cholesterol ☐ Headaches ☐ Lung Disease ☐ Thyroid Disease
☐ Heart Disease ☐ Autoimmune disease (type) _____

Medications _____

Are you pregnant/nursing?_____ Med Allergies _____ Social History: Smoke _____ Drink _____ Drugs _____

FAMILY OCULAR/MEDICAL HISTORY - ☐ No Family History
(Please list your relation- i.e.-mother, maternal grandfather, brother, etc).

☐ Blindness _____ ☐ Diabetes_____ ☐ Other _____
☐ Macular Degeneration _____ ☐ Hypertension _____
☐ Glaucoma _____ ☐ Cancer _____
☐ Lazy eye/Crossed Eyes _____ ☐ Heart/Lung Disease _____

In the event that it becomes necessary for us to release your records to or request from another healthcare professional, I authorize Optic Gallery to release and/or request these records. If applicable, I request payment of authorized Medicare or other insurances be made either to me or on my behalf to Optic Gallery, for any service 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 that 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 deposit made before an 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. I further acknowledge and agree that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. I also acknowledge and agree that in the event I do not pay for services rendered "Optic Gallery" may place my account with a collection agency. I agree to pay reasonable collection fees, attorney fees and court costs incurred in collection of my overdue account.

Signature _____ **Witnessed by** _____ **Date** _____

ADDITIONAL INFORMATION: _____

_____

_____

_____

_____

DILATION OF THE EYES

It will be necessary to dilate your pupils in order to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the internal health of the eyes. The dilating drops typically last 4-6 hours. During this time you may find it difficult to focus at near and less commonly, at distance. You may be sensitive to light. You will be provided with post-dilation glasses.
We strongly recommend caution when driving or operating equipment or machinery after dilation. Signing this section signifies that you have been informed of the risks and benefits of dilation.

Please select one of the options below, indication your choice for Dilation:

▢ I wish to have Dilation performed today ▢ I do not wish to have dilation performed today

▢ I wish to discuss Dilation with the doctor to help with my decision

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES

Signing in this section signifies that you have received a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for these services and to conduct healthcare operations involving our offices.
The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

Signature (patient or guardian) _____ Date _____

DIGITAL COMMUNICATION

I give permission to be in contact via text message, email, and/or Patient Portal with our Electronic Medical Records System.

Signature (patient or guardian) _____ Date _____