

OmniVision Eye Care, P.C.

Name: _____ DOB: ___/___/___ Age: _____ Sex: Male / Female SS#: _____ - _____ - _____

Address: _____ Apt # _____ City: _____ State: _____ Zip _____

Home Phone: _____ Work Phone: _____ Cell phone: _____

Employer: _____ Occupation: _____ Email: _____

**FOR OUR PATIENTS WITH INSURANCE COVERAGE
INSURANCE COVERAGE MUST BE VERIFIED BEFORE TESTING CAN BEGIN**

Insured's Name (Person Responsible): _____ Insured's DOB: ___/___/___

Insured's SS#: _____ - _____ - _____ Relationship to Insured: _____

As a service to our patients, we do our best to verify medical and vision insurance benefits. However, we are not responsible for incorrect benefit information given to us by your insurance company regarding insurance coverage, allowances, co-pays, or other information needed to file an insurance claim. In the event the insurance carrier determines that you are not eligible for coverage at the time of service or makes a determination you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any charges incurred by you and not paid by your insurance provider.

Patient/Guardian Signature: _____ Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that OmniVision Eye Care, P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

I have been offered and/or reviewed the Notice of Privacy Practices which explains how my medical information will be used or disclosed.

I understand I am entitled to receive a copy of the Privacy Practices.

I authorize release of medical information to any physician involved in my care and insurance companies involved in the payment of services rendered on my behalf.

RECHECK POLICY FOR GLASSES AND CONTACTS – please read and acknowledge

- 1. All professional fees are due and payable at the time of service and are non-refundable.
- 2. If a courtesy spectacle recheck is needed, it must be done within 45 days from your initial exam. If a recheck is done 45 days after the initial exam, there will be a \$25 recheck fee. After 6 months, a comprehensive exam is required.

For our patients who will be fitted for contact lenses

- 1. The contact lens evaluation fee covers only visits related to the fit of the contact lens. Fit related issues may include the comfort of the lens and the visual acuity achieved with the lens. Fit related issues DO NOT include, and are not limited to red eye associated with or without contact lens wear, scratched corneas from lens insertion/removal or torn lens, contact lens solution sensitivity, contact lens lodged in the eye, or dry eyes, etc.
- 2. Any follow up visit due to the fit of the contact lens will be covered by the contact lens fee, up to 3 follow up visits. Any follow up visit after the 3rd follow up visit or after 45 days, will be charged the appropriate professional fee. **Therefore, it is important to keep all follow up visits to achieve the optimal contact lens fit within the 45 day global period. If you are using insurance, the contact lens follow policy set forth by your insurance company will be used.**
- 3. A refit to another lens may require an additional contact lens evaluation.

I acknowledge that I have received, read, and agreed to the policies listed above

Patient / Guardian signature

Date

Digital Retina Screening Photography (Please initial the choice you want)

Digital photography of the internal anatomy of the eye is a valuable tool that allows diagnosis and subsequent treatment of ocular disorders. If done annually, the photos form a continuous digital record of the ocular health and over time allows us to monitor intraocular changes that could be indicative of eye disease. **Dr. Bui does recommend this procedure.**

****This screening will cost \$35.00 and your insurance may cover for the procedure. Please ask the receptionist.

_____ **I do want retinal photography**

_____ **I do not want retinal photography**

MEDICAL HISTORY

PATIENT: _____ DOB: _____ AGE: _____ DATE: _____

Patient Symptoms / Needs

Annual vision wellness exam	<input type="checkbox"/> Y <input type="checkbox"/> N	contact lens evaluation	<input type="checkbox"/> Y <input type="checkbox"/> N	
Blurry distance vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Blurry near vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Double vision <input type="checkbox"/> Y <input type="checkbox"/> N
Floaters/spots in vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Flashes in vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Itching <input type="checkbox"/> Y <input type="checkbox"/> N
Temporary loss of vision	<input type="checkbox"/> Y <input type="checkbox"/> N	Burning eye	<input type="checkbox"/> Y <input type="checkbox"/> N	Watering eye <input type="checkbox"/> Y <input type="checkbox"/> N
Glare/light sensitivity	<input type="checkbox"/> Y <input type="checkbox"/> N	Eye pain/soreness	<input type="checkbox"/> Y <input type="checkbox"/> N	Eye discharge <input type="checkbox"/> Y <input type="checkbox"/> N
Frequent headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	No problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Eye Strain <input type="checkbox"/> Y <input type="checkbox"/> N

Patient ocular history (please check all that applies)

Blindness Glaucoma lazy Eye Eye infections
 Turned Eye Trauma Cataracts Poor color vision
 Amblyopia Retina disease Visual blackouts
 Eye Surgeries: _____

Do you wear contacts? Y N Brand? _____
How often do you use a new pair of lenses? _____

How many hours a day do you wear your contacts? _____

Do you sleep in your contacts? Y N
What brand of solution do you use? _____

Medical history (please check all that applies)

Pregnant: months _____ Nursing
 Diabetes: type I or type II hypertension
 Migraines Asthma Thyroid disease
 Heart Condition Allergies

Cancer: _____
 Major Surgeries: _____

Other: _____

* Please list all medications you are taking and **what you are taking them for** (include oral contraceptives, over the counter medications, vitamins, home remedies): _____

* Do you have any drug allergies: _____

FAMILY HISTORY

Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Macular Degeneration	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Lazy eye/Eye turn	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Blindness	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Retinal Detachment	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	Others	<input type="checkbox"/> Y <input type="checkbox"/> N	_____
Other Eye Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	_____			

SOCIAL HISTORY -

Do you Smoke? Y N amount/how long _____ Do you drink alcohol? Y N amount/how long _____
Do you currently drive? Y N if yes, do you have difficulties driving? _____
Do you play sports or engage in outdoor activities? Y N if yes, please list: _____

Patient signature

Date