OMNIVISION **EYE CARE**

New Patient Information

First name:_____ Middle name:_____ Last name:_____ DOB: ___ - ___ - _____

FOR OUR PATIENTS WITH INSURANCE COVERAGE

INSURANCE COVERAGE MUST BE VERIFIED BEFORE TESTING CAN BEGIN

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.

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.

Electronic communications - I authorize OmniVision Eye Care to send patient appointment reminders and important communications to my cell phone and email address.

I authorize the following people to have access to my medical record. I may at any time, send in writing, to remove any of these people from accessing my medical records.

Name: _____ Phone: _____ Relationship to person: _____

Name: _____ Phone: _____ Relationship to person: _____

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 **30 days** from your initial exam. If a recheck is done 31 days after the initial exam, there will be a $32 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 60 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 60 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**

MEDICAL HISTORY

REVIEW OF SYSTEMS (please check any condition you currently have)

GENERAL: ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Fatigue

EAR, NOSE, THROAT: ☐ Allergies ☐ Sinus ☐ Cough ☐ Dry Mouth/ Throat ☐ Loss Of Hearing

CARDIOVASCULAR: ☐ High Blood Pressure ☐ Heart Surgery ☐ Vascular Disease

GASTROINTESTINAL: ☐ Acid Reflux ☐ Intestinal Problems ☐ Liver Problems

GENITOURINARY: ☐ Impotence ☐ Kidney Disease ☐ Bladder Disease

MUSCLES/BONES/JOINTS: ☐ Arthritis ☐ Muscle/joint Pain ☐ Head / Neck Injury

BLOOD/ LYMPH: ☐ Anemia ☐ Bleeding Disorder ☐ High Cholesterol

NEUROLOGICAL: ☐ Headaches ☐ Migraines ☐ Seizures ☐ Numbness

RESPIRATORY: ☐ Asthma ☐ Bronchitis ☐ COPD

IMMUNOLOGIC: ☐ HIV/AIDS ☐ Allergies ☐ Lupus

ENDOCRINE: ☐ Diabetes ☐ Thyroid Disease

PSYCHIATRIC: ☐ Depression ☐ Anxiety Insomnia

INTEGUMENT ARY (SKIN): ☐ Growths ☐ Rashes ☐ Acne

FEMALES: Are you pregnant?: ☐ **N** ☐ **Y** _____ months ☐ Trying to get pregnant ☐ Nursing

Patient Ocular History (please check all that apply)

☐ Blindness ☐ Glaucoma ☐ Lazy Eye ☐ Eye Infections
☐ Turned Eye ☐ Trauma ☐ Cataracts ☐ Poor Color Vision
☐ Amblyopia ☐ Retina Disease ☐ Visual Blackouts
☐ Eye Surgeries: _____
☐ Other: _____

Medical History (please check all that apply)

☐ Diabetes ☐ Thyroid Disease
☐ Hypertension ☐ Arthritis
☐ High Cholesterol ☐ Depression
☐ Seasonal Allergies ☐ Migraines
☐ Other: _____

OCULAR MEDICATIONS ***(PLEASE PRIN1)***

* Please list any EYE DROPS you are using: _____

SYTEMIC MEDICATIONS ***(PLEASE PRIN1)***

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

_____

* **Do you have any drug allergies:** _____

FAMILY EYE HISTORY - if yes to any question, please note the family member

Glaucoma	☐ Y	☐ N	_____	Cancer	☐ Y	☐ N	_____
Macular Degeneration	☐ Y	☐ N	_____	Diabetes	☐ Y	☐ N	_____
Lazy eye/Eye turn	☐ Y	☐ N	_____	Hypertension	☐ Y	☐ N	_____
Blindness	☐ Y	☐ N	_____	Heart Disease	☐ Y	☐ N	_____
Retinal Detachment	☐ Y	☐ N	_____	Others	☐ Y	☐ N	_____
Other Eye Disease	☐ Y	☐ N	_____				

FAMILY MEDICAL HISTORY

SOCIAL HISTORY

Occupation: _____ How many hours a day do you spend on the computer? _____

Employer/School: _____ Do you Smoke? ☐ **Y** ☐ **N** Do you drink alcohol? ☐ **Y** ☐ **N**

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:** _____

Hobbies: _____

Optical History

What is your primary vision correction? ☐ **Glasses** ☐ **Contacts** ☐ **Both** Do you wear sunglasses? ☐ **Yes** ☐ **No**

Age of Current glasses: _____years Do you plan on purchasing new glasses today? ☐ **Yes** ☐ **No** ☐ **Yes, If recommended**

Do you want to be fitted in contact lenses today? ☐ **Yes** ☐ **No**

If you are currendy wearing contacts:

How often do you dispose of you contacts? _____ How many hours a day do you wear contacts? _____

What contact lens solution do you use? ☐ **OptiFree** ☐ **Clear Care** ☐ **Renu** ☐ **Generic** ☐ **Other** _____

How many days out of the week do you wear your contacts? _____

Do you sleep overnight in your contacts? ☐ **Yes, how many days?** _____ ☐ **No** **Do you have backup glasses?** ☐ **Yes** ☐ **No**

_____ _____

Patient / Guardian signature **Date**