

PATIENT INFORMATION

Last name _____ First name _____ MI _____ Nickname _____
Address _____ City _____ State _____ Zip _____
DOB _____ Age _____ Male / Female Driver's license # _____ SSN _____
Home phone _____ Mobile phone _____ Work phone _____
Which phone # would you prefer to be contacted at? Home / Mobile / Work Email _____
Occupation _____ Employer _____
Emergency contact name _____ Phone number _____
Reason for visit: Glasses exam Contact lens exam Both Other _____
Date of last exam _____ Dilated: Yes / No Contacts brand / Rx (if applicable) _____
How old are your glasses? Single _____ yr Bifocal _____ yr Trifocal _____ yr Progressives (no-line) _____ yr
How did you find out about our office? Phonebook Advertisement Drove/Walked by Referred by _____

HEALTH HISTORY

Medication(s) _____ I am, or think I may be, pregnant: Yes / No Male
Are you allergic to any medication(s)? Yes / No If yes, complete the following:
Drug allergies _____ Reaction: _____

Patient Medical History

- Allergies
- Arthritis
- Cancer, type _____
- Cataract
- Diabetes, type _____
- Floaters
- Glaucoma
- Headaches
- High blood pressure
- HIV
- Macular Degeneration
- Other _____

Patient Eye Conditions

- Blurry distance vision
- Blurry near vision
- Burning
- Discharge/matting
- Itching
- Light sensitivity
- Redness
- Watery
- Other _____

Family History

- Arthritis
- Cancer, type _____
- Cataract
- Diabetes
- Glaucoma
- High blood pressure
- Macular degeneration
- Other _____

Please ask our staff if you have any questions.

X _____
Signature of patient (parent/guardian if minor) Print Name Date

FOR CONTACT LENS PATIENTS

Your contact lens prescription will not be finalized until the doctor has checked your trial lenses to determine that they fit properly. At least one follow-up visit is required in order to finalize your prescription, usually one week after your trials are dispensed. **It is your responsibility to keep your follow-up appointment. It is a must you wear your trial contacts when you come in for your visit.** Your supply of contacts will not be ordered until your prescription is finalized.

IF YOU DO NOT COME IN WITHIN 30 DAYS OF YOUR INITIAL VISIT, A \$50 OFFICE VISIT FEE WILL BE ASSESSED.

_____ (Please initial)

CANCELLATION POLICY

We require at least 24 hours advanced notice for any changes or cancellations of your appointment. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. **We will charge a \$50.00 fee for patients who do not show up for their scheduled appointments and for patients who fail to give us sufficient notice that they have a conflict.**

We reserve time in our schedule for you in advance in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment. **Patients with a history of failing appointments or repeated late cancellations may be dismissed from the practice.**

_____ (Please initial)

VISION INSURANCE

Do you have VISION INSURANCE? Yes / No

If yes, complete the following:

Vision insurance _____ Primary's full name _____

Primary's SSN _____ Primary's employer / ID# (if applicable) _____

Primary's date of birth _____ Primary's occupation _____

Relationship to primary Self Spouse/Domestic Partner Child Other _____

I authorize Uptown Vision to perform all necessary tests to insure proper diagnosis and treatment of any eye conditions. I also authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance if the Practice does not participate with my insurance. I realize that insurance benefits **must be presented and verified** at the time of service date. We cannot refund you for insurance benefits that were not verified at the time of service date.

_____ (Please initial)

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve Uptown Vision of all liability. I give my consent to fax my records for the purpose of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

_____ (Please initial)

Please ask our staff if you have any questions.

X _____
Signature of patient (parent/guardian if minor)

Print Name

Date

DILATION/OPTOMAP & VISUAL FIELD SCREENING INFORMED CONSENT

We are committed to maintaining the highest level of care for the early detection and prevention of eye disease. Our doctors strongly advise an annual retinal health examination for every patient.

There are two ways your retina can be examined. We would like you to choose one of the following options for your exam:

OPTION #1: OPTOMAP

Optomap offers a **non-invasive and painless alternative to traditional dilation** by capturing a digital scan of the retina in less than a second, with no side effects. A healthy retina is critical to vision and needs to be examined for problems such as macular degeneration, glaucoma, cataracts, holes/detachments and complications from high blood pressure, diabetes, and HIV, etc.

The scans become permanent records that will assist the doctor to monitor and compare any changes annually helping maintain good eye health. **It is the doctor's preferred method of evaluating the internal health of your eye.**

The fee for the Optomap is \$40.00. Your vision insurance will not cover this procedure.

Yes, I consent to having the Optomap (in lieu of a standard dilated exam) today.

No, I do not consent to having the Optomap (in lieu of a standard dilated exam) today.

OPTION #2: DILATION with OR without REVERSAL DROPS

Dilation involves instilling eye drops to enlarge the pupils and to obtain a better view of the back of the eyes. Dilation causes **blurriness of near vision for 4-6 hours and increased sensitivity to light**. Distance vision will not be affected for most patients. There will not be any permanent graphic records available for comparison to previous exams. **DILATION IS PART OF A ROUTINE EXAMINATION AND COVERED BY YOUR VISION INSURANCE.**

DILATION REVERSAL DROPS

Dilation reversal drops are available to reduce the amount of time that your pupils stay dilated so that you may resume your normal activities shortly after your eye exam. Once the reversal drops are instilled, your pupils will return to normal size within an hour. Without the drops, the effects of dilation usually last around 4-6 hours. Dilation reversal drops will cause temporary, but not harmful, eye redness.

The fee for instillation of reversal drops is \$20.00. Your insurance will not cover this procedure.

Yes, I consent to having the dilation reversal drops.

No, I do not consent to having the dilation reversal drops.

VISUAL FIELD SCREENING

The visual field screening, tests the integrity of the optic nerve pathway. It is a non-invasive computerized test which helps detect early signs of glaucoma, optic nerve disorders, retinal diseases and even certain brain tumors. We recommend this test for all of our patients.

The fee for the visual field test is \$ 15.00. Most insurance does not cover this procedure.

Yes, I consent to having my visual field tested today.

No, I do not consent to having my visual field tested today.

Please ask our staff if you have any questions.

X
Signature of patient (parent/guardian if minor)

Print Name

Date