PATIENT INFORMATION

EXAM DATE: / /

LAST NAME _____ FIRST NAME _____ ☐ M ☐ F BIRTH DATE / /

ADDRESS _____ CITY _____ STATE PROVINCE _____ ZIP POSTAL CODE _____

PREFERRED TELEPHONE NUMBER ( ) _____ HOME WORK CELL (CIRCLE ONE) SECONDARY TELEPHONE NUMBER ( ) _____ HOME WORK CELL (CIRCLE ONE)

WE USE PHONE CALLS TO REMIND PATIENTS OF THEIR APPOINTMENTS. WE WILL USE THE PHONE NUMBER YOU PROVIDE AND THE CALL MAY BE LIVE OR PRERECORDED.

EMPLOYER _____ OCCUPATION _____

REFERRED BY _____ EMAIL ADDRESS _____ SIGNATURE _____

INSURANCE INFORMATION

PLAN NAME _____ GROUP _____

INSURED NAME _____ RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD (CHECK ONE)

INSURED ID# _____ INSURED DATE OF BIRTH / /

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM? _____

AGE OF PRESENT GLASSES _____ AGE OF SUNGLASSES _____ DATE OF LAST EYE EXAM / / FROM DR. _____ PREVIOUS PATIENT? ☐ YES ☐ NO

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
DIABETES	☐	☐	☐	GLAUCOMA	☐	☐	☐	DO YOU SEE DOUBLE?	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	CATARACTS	☐	☐	☐	FREQUENT HEADACHES?	☐	☐
THYROID PROBLEMS	☐	☐	☐	RETINAL DISEASE	☐	☐	☐	ARE YOU PREGNANT?	☐	☐
HEART DISEASE	☐	☐	☐	EYE SURGERY	☐	☐	☐	EYES BEEN DILATED?	☐	☐ YEAR? _____
ASTHMA	☐	☐	☐	EYE INJURY	☐	☐	☐	PRIMARY CARE DR. _____		
CANCER	☐	☐	☐	OTHER _____	☐	☐	☐			

PLEASE EXPLAIN ANY POSITIVE FINDINGS: _____

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST. _____

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST. _____

DO YOU HAVE ANY ALLERGIES, MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN. _____

ARE YOU PLANNING TO GET NEW GLASSES TODAY? ☐ YES ☐ NO

ARE YOU HAVING ANY PROBLEMS WITH YOUR VISION? ☐ FAR AWAY ☐ CLOSE UP ☐ IN BETWEEN

WHAT DO YOU LIKE/DISLIKE ABOUT YOUR CURRENT EYEWEAR? ☐ WEIGHT ☐ THICKNESS ☐ FIT ☐ STYLE ☐ SHAPE ☐ DURABILITY ☐ SIZE ☐ COLOR

WHAT TYPE OF WORK DO YOU DO? _____ HOW MANY HOURS PER DAY ARE YOU ON THE COMPUTER? _____

DO YOUR EYES TIRE WHEN READING? ☐ YES ☐ NO WHEN DO YOU HAVE PROBLEMS WITH BRIGHT LIGHTS OR GLARE? ☐ DAY ☐ NIGHT

WHEN DO YOU NOTICE THIS? ☐ ON-COMING HEADLIGHTS ☐ COMPUTER SCREEN ☐ GLARE FROM WINDSHIELD ☐ SUNLIGHT

WHAT TYPE OF SUN PROTECTION DO YOU CURRENTLY WEAR? _____ ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? ☐ YES ☐ NO

WHAT DO YOU LIKE/DISLIKE ABOUT YOUR CURRENT CONTACTS? ☐ VISION ☐ COMFORT ☐ OXYGEN ☐ DRYNESS ☐ COLOR ☐ ITCH

WHEN DO YOUR CONTACTS FEEL DRY? _____ HOW OFTEN DO YOU SLEEP WITH THEM? _____

HAVE YOU EVER WORN CONTACTS? ☐ YES ☐ NO DO GLASSES GET IN THE WAY OF ANY ACTIVITIES (GOLF, SWIMMING, ETC.)? ☐ YES ☐ NO

Receipt of Notice of Privacy and Consent Form

Apple of My Eye Optometry
6160 Arlington Ave C1, Riverside, CA 92504
(951)977-8635
info@AppleOfMyEyeOptometry.com

Patient Name: _____

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 our services and conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosure in detail. You are free to refer to this notice any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices.*** Our ***Notice of Privacy Practices*** will be updated whenever our privacy practice changes. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose you information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices.***
You have the right to ask us to restrict the uses or disclosures made for purpose of treatment, payment or healthcare operations, bus as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Apple of My Eye Optometry.

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient Print Name

Language Preference: English, Spanish, other (please list):_____
If patient is limited in English proficiency, would patient like Language assistance? YES NO

Apple of My Eye Optometry

6160 Arlington Ave C1, Riverside, CA 92504
Phone: (951)977-8635
Fax: (951) 977-8637

RETINAL PHOTO CONSENT FORM

As part of your exam, we at Apple of My Eye Optometry recommend a special diagnostic procedure called **RETINAL PHOTOS**. This procedure consists of taking a photograph of the back part (retina) of your eye, and is suggested for both adults **and** children.

This permanent record is very valuable in assessing the health of your eye and safeguarding the health of your retina, optic nerve, macula and blood vessels. It will also serve as an initial point with which to compare as we follow your health in subsequent years.

- In most cases, DILATION IS NOT NEEDED for retinal photos.
- The Fee for this additional part of your eye exam is **$20.00** for both eyes.
- Not Covered by Insurance
- Photo is Optional but Highly recommended

_____ YES, I consent to retinal photos

_____ NO, I DO NOT consent to retinal photos

PLEASE DISCUSS ANY ADDITIONAL QUESTIONS YOU MAY HAVE ABOUT PHOTOS WITH THE DOCTOR DURING YOUR EXAM.

Signature Date