

Patient History Questionnaire

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone #: _____ Email: _____

Emergency Contact: _____ Phone #: _____

Date of Last Eye Exam: _____ Occupation: _____ Employer: _____

MEDICAL HISTORY

Check all that apply to you:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	Diabetes: <input type="checkbox"/> Type 1 <input type="checkbox"/> Type II
<input type="checkbox"/> Thyroid issues	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Cancer
<input type="checkbox"/> Respiratory issues	<input type="checkbox"/> Auto-immune disorder	<input type="checkbox"/> Other:

Current Medications: _____

Drug Allergies: _____

EYE HISTORY

Check all that apply to you:

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Retinal Detachment
Other:			

Check all that apply to your family history:

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Retinal Detachment
Relation:	Relation:	Relation:	Relation:

Do you wear glasses? Yes No If so, for what? Far Near Both

Do you wear contacts? Yes No If so, what brand do you wear? _____

Please provide any Ocular Surgeries with date(s): _____

Any concerns or questions for the doctor? _____

Consumer Optical Co., Inc. Cancellation Policy:

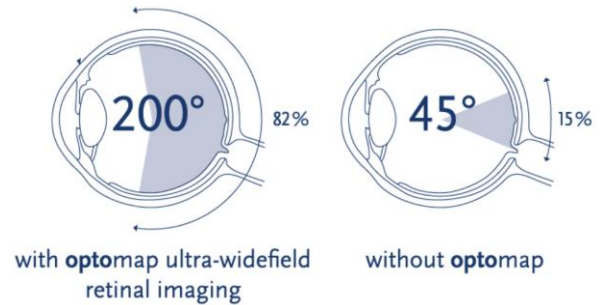
A notice of 24 hours prior to an appointment is required for cancellation. If an appointment is cancelled with less than 24 hours notice a \$50 fee is required prior to scheduling of an appointment.

Signature: _____

Date: _____

What is an Optomap?

- An ultra-widefield image that provides a 200 degree high resolution view of the back of the eye **without** the need of dilation drops



What are the benefits of Optomap retinal imaging?

- Early detection of sight-threatening conditions such as **retinal detachments, glaucoma, or macular degeneration**
- Early detection of systemic diseases such as **cardiovascular disease, stroke, or cancer**
- Allows eye doctor to precisely track changes over time better than standard eye exams
- Although we recommend dilation as well, it may alleviate the need for dilation
- Takes less than 1 min per eye

Vision insurance covers a basic eye exam and mostly likely does not cover advanced screening tools such as Optomap. We have invested in this state of the art technology because we believe it is in our patients' best medical interest to have this retinal scan. **The cost of the Optomap is \$39.**

- Yes, I would like an Optomap performed today so the doctor can further assess my retinal health**
- I would like to discuss further with the doctor
- No, thank you

What is dilation?

- Dilation, which is part of a comprehensive eye exam, is the use of pharmaceutical eye drops to dilate the pupils to allow the doctor to assess the entirety of the back of the eyes
- ***Side effects of dilation can last 1-3 hours and can include increased sensitivity to light, which may make driving more difficult, and decreased focusing/reading***

- Yes, I would like to be dilated today
- No, I don't want to be dilated today

Consumer Optical Co., Inc. Disclosures:

HIPAA Privacy Policy:

I understand Consumer Optical Co., Inc. may not use nor disclose protected health information to another party, unless it is to permit Consumer Optical Co., Inc. to perform administrative duties, provide me with eye care services/referrals and products, process my vision and health benefit claims and communicate with me regarding vision care services provided by Consumer Optical Co., Inc. I can be assured that Consumer Optical Co., Inc. does not sell my protected health information of any kind, and/or the vision services and products that I have received to a third party for such party's own use. I understand I can receive a more detailed HIPAA privacy policy upon request.

I give Consumer Optical Co., Inc. permission to:

Leave <i>appointment</i> information by:	Leave <i>medical</i> information by:
<input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Voicemail <input type="checkbox"/> Mail <input type="checkbox"/> Another Person (list below)	<input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Voicemail <input type="checkbox"/> Mail <input type="checkbox"/> Another Person (list below)

Other person(s) authorized to communicate with Consumer Optical Co., Inc.: _____

Patient Financial Responsibility:

I understand that Consumer Optical Co., Inc. will be billing my insurance company. I understand that it is my responsibility to read and understand my insurance coverage. If, for any reason, my insurance company does not pay Consumer Optical Co., Inc. for services provided, I agree to pay Consumer Optical Co., Inc. in full for all services rendered.

Explanation of Coverage:

Vision insurance is for routine eye exams which includes an annual eye exam, with refraction, to evaluate the health of the eyes and determine the need for glasses and/or contacts. These plans may also provide benefits for the purchase of glasses and/or contacts.

Medical insurance provides coverage for diagnostic testing and medical treatment for a medical diagnosis such as glaucoma, macular degeneration, diabetes, hypertension, dry eye, conjunctivitis, cataracts, etc. Medical insurance does not cover the cost of a refraction (\$50) and the patient is responsible for this fee.

Until a routine eye exam has been completed, it is not possible to determine if a medical diagnosis exists that may require additional testing. If a medical diagnosis is identified, Consumer Optical Co., Inc. is required by our vision and medical contractual obligations to submit the claim(s) to the appropriate carrier(s). In the event we do not participate with your insurance plan we will provide an itemized receipt so that you may file with your carrier for any out-of-network benefits.

Release of Liability for Internal Eye Health Exam:

I have been informed that a thorough internal examination (dilation/Optomap) is integral to an eye exam and without it, serious eye and systemic diseases indicators can be missed that can lead to blindness and/or serious health issues.

By signing below, I understand and agree to the above disclosures:

Signature: _____

Date: _____