New View OPTOMETRY

# Patient Paperwork

**First Name:** _____ **Last Name:** _____ **M.I.**____

**Today's Date:** _____ **Last Eye Exam:** _____

**I prefer to be called:**_____ **Occupation:**_____

**Date of Birth:** ____/____/_____ **SSN:**_____-_____-_____ **Preferred Contact? PHONE / EMAIL / TEXT**

**Address:** _____ **City:** _____

**State:** _____ **Zip:** _____ **Parent/Guardian (if applicable):**_____

**Home Phone:**_____ **Cell Phone:**_____ **Work Phone:** _____

**Email:** _____

**What hobbies, activities, and/or sports do you enjoy?** _____

**Do you use a computer?**_____ **How many hours per day?** _____

**Primary Care physician:** _____**Preferred Pharmacy:**_____

**Referred by (Doctor or personal):** _____

**How did you hear about us? (Facebook, Instagram, Google, newspaper, website, drive-by):** _____

## Primary Reason for Visit: (Please Check One)

### ☐ Routine Comprehensive Exam

Today I am Needing an…

☐ Updated Glasses Prescription

☐ Updated Contact Lens Prescription

Symptoms you are currently experiencing:

____ Blurred Vision
____ Reduced Night Vision
____ Eye Strain

### ☐ Problem Focused Office Visit

Symptoms you are currently experiencing:

____ Noticeable Redness
____ Light Sensitivity
____ Excessive Tearing
____ Pain or Discomfort
____ Flashes or Flickers
____ Reduced Side Vision
____ Halos around Lights
____ Burning Eyes
____ Itchy, Watery Eyes
____ Dry, Gritty Feeling
____ Light Sensitivity
____ New Floaters/Spots
____ Loss of Vision
____ Double Vision

Any previous surgeries or injuries to your eyes?_____ If so, please describe_____

_____

Using any ocular medicines? Please list if known: _____

Have you ever been diagnosed with, or treated for, any of the following ocular conditions?

| | | | | | |
|---|---|---|---|---|---|
| Retinal Detachment | ____ | Ocular Infections | ____ | Lazy or Turned Eye | ____ |
| Cataracts | ____ | Glaucoma | ____ | Styes, Inflamed Lids | ____ |
| Macular Degen. | ____ | Disease of Retina | ____ | Keratoconus | ____ |

Do you currently wear glasses? **YES / NO** If so, how old are they? _____

What do you wear them for? ____Distance ____Computer ____Reading ____Full-Time

**Medical History**: (The following information is needed in order for the doctor to perform a thorough exam and/or at the request of insurance for filing purposes.)

Do you have any allergies to medicines? **YES / NO** If so, please list: _____

Are you taking any Rx or OTC medicines? **YES / NO** If so, please list: _____

_____

Are you pregnant or nursing? _____ If pregnant, list due date:_____

Any previous injuries, surgeries, or hospitalizations? _____

_____

Have you been diagnosed with or treated for any of the following problems? (Check all that apply)

**Constitutional:**
☐ Development Disability
☐ Weight Gain/Loss
☐ Cancer
Specify:_____
☐Fatigue Syndrome
☐ Other:_____
**ENT:**
☐ Hearing Loss
☐ Sinusitis
☐ Dry Mouth
☐ Laryngitis
☐ Other:_____
**Integumentary:**
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Herpes Simplex/Cold Sores
☐ Herpes Zoster/Shingles
☐ Other:_____

**Psychiatric:**
☐ Depression
☐ Attention Deficit
☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Other:_____
**Cardiovascular**
☐ High Blood Pressure
☐ Stroke / CVA
☐ Heart/Vascular Disease
☐ Congestive Heart Failure
☐ Other:_____
**Muskuloskeletal:**
☐ Arthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Osteoporosis
☐ Ankylosing Spondylitis
☐ Other:_____
**Endocrine:**
☐ Diabetes
**Type 1** or **Type 2**
☐ Thyroid Dysfunction
**Hypo** or **Hyper**
☐ Hormonal Dysfunction

**Genitourinary:**
☐ Kidney Disease
☐ Prostate Disease/Cancer
☐ STD Herpetic/Chlamydia
☐ Syphilis
☐ Pregnant/Nursing
☐ Other:_____
**Respiratory:**
☐ Smoker (current/former)
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic Obstruction
☐ Other:_____
**Gastrointestinal:**
☐ Crohn's
☐ Ulcerative Colitis
☐ Acid Reflux
☐ Celiac Disease
☐ Other:_____
**Hematological/Lymphatic:**
☐ Anemia
☐ Ulcer
☐ Elevated Cholesterol
☐ Other:_____

**Immunological:**
☐ Drug Allergies
☐ Environmental Allergies
☐ Rheumatoid Arthritis
☐ HIV / AIDS
☐ Mononucleosis
☐ Lupus
☐ Sjogren's Syndrome
☐ Autoimmune Disease
Specify:_____
☐ Other:_____
**Neurological:**
☐ CP/MS/MD/MG
☐ Epilepsy
☐ Cerebral Palsy
☐ Bell's Palsy
☐ Tumor
☐ Stroke/CVA
☐ Seizures
☐Migraines
☐Autism
☐ Other:_____

**Any other medical issues not listed above:** _____
**Allergies:** (seasonal, food, etc.) Please list: _____
Any Latex sensitivity? **YES / NO**
**Social History:** Do you drive? **YES / NO** If yes, are you having any visual difficulties?_____
Do you use tobacco products? **YES / NO** If so, how often? _____
Do you use alcohol? **YES / NO** If so, how often? _____
Do you have a history of drug or alcohol abuse? **YES / NO** If yes, how long? _____
Have you ever been exposed to HIV or other sexually transmitted diseases? **YES / NO**
**Family Medical History:**
In your immediate family, is there any history of the following conditions? (Circle all that apply)

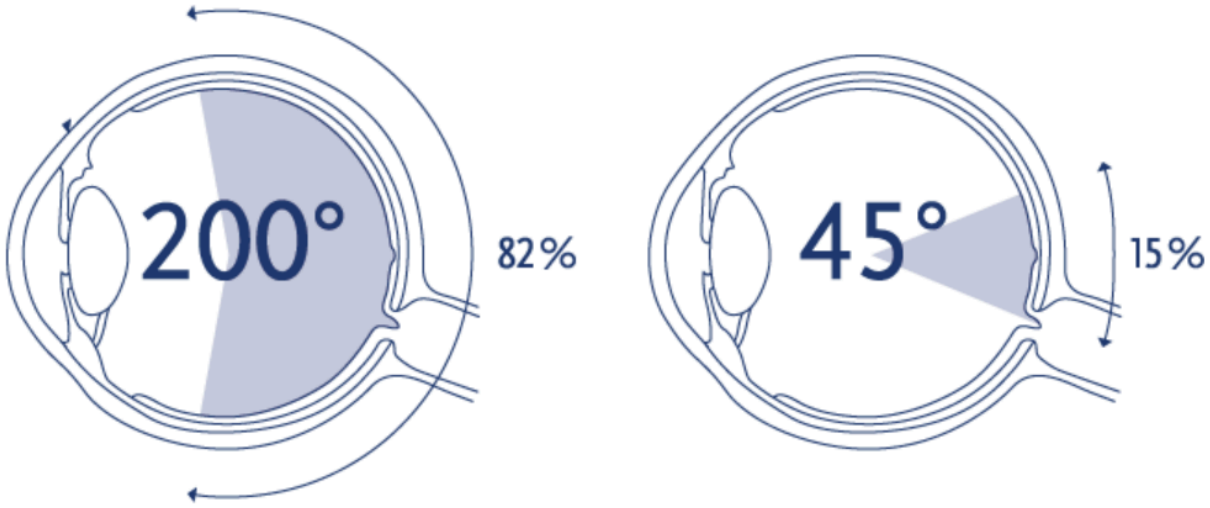
| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Blindness: Injury/Disease | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Turned or Lazy Eyes | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Cataracts | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Glaucoma | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Macular Degeneration | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Retinal Detach/Disease | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Arthritis | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Cancer | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Heart Disease | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| High Blood Pressure | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Kidney Disease | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Lupus | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Diabetes: ***(Check one)*** | | | | | | | |
| ___ ***Type 1*** ___ ***Type 2*** | ____ | Father | Mother | Brother | Sister | Son | Daughter |
| Thyroid Disease: ***(Check one)*** | | | | | | | |
| ____ ***Hypo*** ___***Hyper*** | ____ | Father | Mother | Brother | Sister | Son | Daughter |

# iCare Retinal Imaging

**An internal health check is required in order to update your prescription.** Traditionally, the internal exam was performed using dilating eye drops. At New View Optometry, our doctors have invested in state-of-the art **retinal imaging** technology as an alternative to the dilating drops.

Retinal Imaging allows us to evaluate your retina to better diagnose diseases such as diabetic retinopathy, glaucoma, cancers of the eye - as well as macular degeneration, retinal holes, bleeding in the retina and retinal detachments without dilation drops.

- safe, painless, and fast **(Save 30 minutes on your visit vs a dilated exam!)**
- **no blurry vision**
- a permanent digital record compared year to year for changes and/or abnormalities.
- does not require dilating drops.
- safe for adults and children.
- larger and magnified view of the retina




With iCare widefield Retinal Imaging VS. Without iCare Retinal Imaging

**I have read and understand the above, and agree to the iCare Retinal Imaging negotiated Copay of $_39__ with _____.**

Insurance/self pay

_____

Patient name, please print

_____ _____

Patient Signature Date

If you wish to decline retinal imaging please initial here that you consent to the dilation drops and fully understand the side effects (temporary discomfort such as stinging/burning with installation, light sensitivity and impaired near vision for about 5 hrs) and that my appointment time will be longer by approximately 30 to 45 minutes. _____

If the doctor decides there is still a need for dilation, this will be discussed during your exam.
***The Texas Board of Optometry requires an internal exam for all new and established patients.***

## OCT Wellness Imaging

Optical Coherence Tomography (OCT) is an ADVANCED retinal scan through the deeper layers of the retina. This is useful for early detection of retinal diseases, like macular degeneration. This is NOT the same as having retinal imaging. ***This test is recommended more for patients who are 50 or older, patients with diabetes or patients with a family history of any sight threatening retinal eye conditions. EARLY detection is crucial!***

Please Choose One:

☐ I elect to have an OCT scan of my retina today - Copay of $25

☐ I am declining the OCT scan

# Patient Insurance Information

**Vision Plan or Medical Insurance being billed today:**

Primary's Name: _____ Primary's DOB: _____/_____/_____
Name of Plan or Insurance: _____ Primary's Employer: _____
Member ID or SSN Number: _____ Group Number: _____

### Medical Consent to Treatment

The doctor at New View Optometry is licensed to provide both routine vision exams and medical eye exams. If you are here today for a routine vision exam and your complaint or initial assessment indicates that there is a significant medical condition that requires treatment, you will be either provided with appropriate treatment today; referred to the appropriate specialist for treatment; or rescheduled for a medical examination. New View Optometry is not a contracted provider for medical visits so the charges for your visit will be payable at the time of service. The doctor will discuss any such condition with you prior to initiating medical treatment, and it is your responsibility to consent to treatment or request referral to the appropriate specialist.

### Acknowledgements and Signature

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to New View Optometry. **I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges.** I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event it becomes necessary to place any unpaid balances I am responsible for in collection, I agree to pay any collection fees, reasonable attorney fees, filing fees, and other costs the court determines are proper. I have read the conditions of service, and as the Patient or the Patient's Authorized Representative I hereby accept these terms.

Your eye prescription and circumstance for usage are, like you, completely unique. When prescription eyeglasses and specialty contact lenses are ordered and accepted upon fitting, returns and repairs are acceptable only under the terms of warranty set forth by the manufacturer and are repairable as diagnosed and authorized by the manufacturer only. Returns for any reason other than manufacturer's warranty are prohibited due to the individual nature of the prescription eyecare order. Appointments for troubleshooting on eyewear purchased elsewhere will incur a charge. Appointments for troubleshooting eyewear purchased in-house will have this charge waived.

***HIPAA Notice and Acknowledgement***

I acknowledge that I have been provided the HIPAA Notice of Privacy Practices ___**Yes** ____**No**

**Signature of Patient or Responsible Party** _____ **Date:** _____

# Glasses Prescription Acknowledgement

New View OPTOMETRY

**After the completion of your Refractive Eye Exam you will receive a copy of your updated Glasses Prescription from today's visit as well as a detailed receipt for your Refractive Eye Exam.**

**In an effort to save paper our office will be emailing these documents to you at the email address you have provided us with, please keep in mind that emails are not encrypted. If you wish to have paper copies of these documents please indicate that below:**

☐ **I would like to receive a paper copy of my documents**

**By signing below I acknowledge that I will be receiving my Eyeglass Prescription and Refractive Eye Exam Receipt electronically through my email unless I have indicated otherwise by checking the above box.**

**Patient Name** _____ **Date:**_____

**Patient Signature** _____

**Please Confirm your Email Address:**_____

# Contact Lens Fitting and Acknowledgement

**Do you currently wear contact lenses? YES NO**

**What type/brand? _____ Hours per day**? _____

The contact lens portion of the eye exam is separate from the medical/routine exam performed by the doctor. Every year, your lenses need to be reevaluated to ensure that they are a proper fit and the healthiest option for your eyes. A poor-fitting lens can affect the health of your eyes. Most insurance companies have a fitting co-pay or will discount the fitting for you; any remaining balance after insurance benefits is the patient's responsibility. This fee can vary depending on the changes that need to be made to your current contact lenses. Even lenses that seem okay may sometimes need to be changed to maintain good vision and eye health. At the time of your exam, your needs will be determined by the doctor and you will be informed of your co-pay and cost.

- Any follow up contact evaluations/adjustments that need to be made to your prescription or fit are covered under your fitting fee within **90 days** of your initial fitting.
- After 90 days and within **6 months** of your initial fitting, changes can be made with a **$35** office visit.

**90 days after your initial fitting, your prescription will be considered finalized if we have not heard from you.**

**Any changes needed will require a new fitting to ensure that your prescription has not changed and you are not experiencing any health issues with your eyes.**

For soft and RGP lens wearers, a copy of your contact lens prescription can be printed or emailed* to you upon finalization of your fitting. This can be filled wherever you would like. *keep in mind email is not encrypted.

***Included below is important information to review prior to receiving your contact lens prescription.***

The Centers of Disease Control and Prevention (CDC) states that "Contact lenses can provide many benefits, but they are not risk-free--especially if contact lens wearers don't practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor. However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment."

**1. The CDC recommends the following for contact lens wearers:**

➢ Schedule a visit with your eye doctor at least once a year.

➢ Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision.

➢ Understand that eye infections that go untreated can lead to eye damage or even blindness.

**2. The Food and Drug Administration (FDA) indicates:**

➢ To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It's safer to be re-checked by your eye care professional."

**3. Symptoms of eye infection include:**

❖ Irritated, red eyes

❖ Worsening pain in or around the eyes -- even after contact lens removal

❖ Light sensitivity

❖ Sudden blurry vision

❖ Unusually watery eyes or discharge

**By signing below, I acknowledge that I have read and understand this agreement. I agree to wear my contacts no longer than prescribed by the doctor, agree to properly care for my contact lenses as instructed and agree to return for recommended follow-up visits. I understand the current fitting fee policy and my responsibilities as a contact lens wearer.**

Patient Name: _____ Date: _____

Patient Signature: _____