Arvada Optometric Center

Patient Information

Name: ____ Today's Date: ________________

Gender: ❑ Male ❑ Female Occupation: ____________________

Address: ____ Home Phone: __________________

City: ______________________State: _____ Zip: __________ Work Phone: ___________________

Date of Birth ___-___-____ Age: ____ SS# ____-____-____ Cell Phone: _____________________

Do you consider yourself Hispanic/Latino? ❑ Yes ❑ No ❑ Decline

Race: ❑ White ❑ American Indian ❑ Asian ❑ African American ❑ Native Hawaiian ❑ Decline

Preferred Language_____________ Email: ____

Parent/Guardian (if Applicable): ___________________________ Last Eye Exam _________________

Name of Primary Care Physician: _________________________ Last Medical Exam _____________

New Patients Only:

Whom may we thank for referring you to us? ____

Who prescribed your last glasses/contacts? ______________ How long ago? _____________________

What do you like or dislike about your present glasses or previous eye care experience?

____

Vision Insurance

Insured's Name: ________________________Date of Birth: ___-___-____ Relationship: ________________

Insured's Employer's Name: _____________________ Insurance Provider: _________________________

Insured's Member ID/SS Number: ________________ Insured's Group Number:______________________

Primary Medical Insurance OR Secondary / Supplement for Medicare Only

Must present ID card to scan into system

Insured's Name: ___________________________ Date of Birth: ___-___-____ Relationship: __________________

Insured's Employer's Name: __________________ Insurance Provider: _________________________

Insured's Member ID Number: ________________ Insured's Group Number: _______________________

____

Patient Notification – Consent to Treatment

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, pre-test findings the Doctor may find it necessary to bill your exam medically as well as order additional tests. You will be notified during the course of the exam by the Doctor if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and is subject to their specific copays, deductibles, and co-insurance, which will be due at time of service.

Financial Acknowledgements

I hereby authorize any person/institution rendering care to furnish all facts concerning this claim. I authorize payment for my vision benefits to go directly to Arvada Optometric Center. I authorize Arvada Optometric Center to deposit checks received on my account made out to me for services rendered. **I agree that if my employer, insurance carrier or plan sponsor denies payment to all of or any portion of my claim, I will be financially responsible for all outstanding charges.** In the event is should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest at the rate of 1.5% per month/18% per year, collection fees, and should legal action be filed, reasonable attorney fees, filing fees, and other costs the court determines proper. **Authorization obtained at time of service does not guarantee payment and any denied services will be balance billed to patient.**

Patient/Guardian Signature: ___________________________________ Date:___________________

Medical History Questionnaire

Chief Complaint – Eyes -Are you currently experiencing any of the following:

Blurred Vision	❑ Yes ❑ No	
Burning	❑ Yes ❑ No	
Distorted Vision/ Halos	❑ Yes ❑ No	
Double Vision	❑ Yes ❑ No	
Dryness/Dry Eyes	❑ Yes ❑ No	
Excess Tearing/Watering	❑ Yes ❑ No	
Eye Pain or Soreness	❑ Yes ❑ No	
Flashes/Floaters in Vision	❑ Yes ❑ No	
Foreign Body Sensation	❑ Yes ❑ No	
Glare/Light Sensitivity	❑ Yes ❑ No	
Itching	❑ Yes ❑ No	
Loss of Side Vision	❑ Yes ❑ No	
Loss of Vision	❑ Yes ❑ No	
Mucous Discharge	❑ Yes ❑ No	
Redness	❑ Yes ❑ No	
Sandy or Gritty Feeling	❑ Yes ❑ No	
Tired Eyes	❑ Yes ❑ No	

Has there been a change in your vision since your last exam? ❑ Yes ❑ No

If yes, explain:____

Ocular Conditions - Do you currently have or have you been diagnosed with the following:

Cataracts	❑ Yes ❑ No
Crossed Eyes	❑ Yes ❑ No
Drooping Eyelid	❑ Yes ❑ No
Eye Injury	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No
Infection of Eye or Lid	❑ Yes ❑ No
Lazy Eye	❑ Yes ❑ No
Retinal Disease	❑ Yes ❑ No
Styes or Chalazion	❑ Yes ❑ No
Eye Surgeries	❑ Yes ❑ No

Medical History

Do you have any allergies to medications? ❑ Yes ❑ No If yes, explain:______________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and herbal supplements.)________________________________

____

List all major injuries, surgeries and/or hospitalizations you have had: ______________________________

____

Are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Do you wear glasses? ❑ Yes ❑ No If yes, how old is your present pair of lenses? ________________

Do you wear contact lenses? ❑ Yes ❑ No If yes, how old is your present pair of lenses? ________________

Type of contact lenses? ❑ Rigid ❑ Soft ❑ Extended ❑ Other Are they comfortable? ❑ Yes ❑ No

How often do you replace your contacts? ____

Do you sleep in your contacts? ❑ Yes ❑ No

If so, how many consecutive nights? ____

With whom can we share your medical information?

Name	Relationship

Family Diseases / Conditions

Condition			Relationship to You
Blindness	❑ Yes	❑ No	______________________
Cataracts	❑ Yes	❑ No	______________________
Crossed Eyes	❑ Yes	❑ No	______________________
Glaucoma	❑ Yes	❑ No	______________________
Macular Degeneration	❑ Yes	❑ No	______________________
Retinal Detachment/ Disease	❑ Yes	❑ No	______________________
Arthritis	❑ Yes	❑ No	______________________
Cancer	❑ Yes	❑ No	______________________
Diabetes	❑ Yes	❑ No	______________________
Heart Disease	❑ Yes	❑ No	______________________
High Blood Pressure	❑ Yes	❑ No	______________________
Kidney Disease	❑ Yes	❑ No	______________________
Lupus	❑ Yes	❑ No	______________________
Thyroid Disease	❑ Yes	❑ No	______________________
Other	❑ Yes	❑ No	______________________

Social History

This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you have visual difficulty when driving? ❑ Yes ❑ No ❑ N/A

If yes, please describe: ____

Hobbies: ____

Do you use tobacco?	❑ Yes	❑ No	If yes, type/amount/how long: ________________
Do you drink alcohol?	❑ Yes	❑ No	If yes, how often: ________________
Do you use Marijuana?	❑ Yes	❑ No	If yes, type/amount/how long: ________________
Do you use illegal drugs?	❑ Yes	❑ No	If yes, type/amount/how long: ________________

Health History

Condition	Yes	No
Allergy	❑ Yes	❑ No
Cardiovascular		
Heart Problems	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
Constitutional		
Fever	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No
Weight Gain	❑ Yes	❑ No
Integumentary (Skin)	❑ Yes	❑ No
Cranial/Facial		
Chronic Cough	❑ Yes	❑ No
Dry Mouth	❑ Yes	❑ No
Ear Infection	❑ Yes	❑ No
Sinus Congestion	❑ Yes	❑ No
Endocrine		
Diabetes	❑ Yes	❑ No
Thyroid/Other Glands	❑ Yes	❑ No
Gastrointestinal		
Constipation	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
Genitourinary		
Bladder	❑ Yes	❑ No
Kidney	❑ Yes	❑ No
Hematologic/Lymphatic		
Anemia	❑ Yes	❑ No
Bleeding Problems	❑ Yes	❑ No
Immunologic		
Syphilis	❑ Yes	❑ No
Musculoskeletal		
Arthritis/ Rheumatoid	❑ Yes	❑ No
Joint Pain	❑ Yes	❑ No
Muscle Pain	❑ Yes	❑ No
Neurological		
Headaches	❑ Yes	❑ No
Migraines	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Psychiatric	❑ Yes	❑ No
Respiratory		
Asthma	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No

Our Doctors highly recommend an OPTOS with your routine examination. An OPTOS is an instrument that scans your retina and gives us high-resolution photos of your optic nerve head and macular area. This permanent addition to your record helps the doctors more closely follow you for conditions such as Macular Degeneration, Glaucoma, retinal changes associated with diabetes and other potential visual diseases. This testing will be offered during your pre-testing.

Thank you for the opportunity of allowing Arvada Optometric Center to care for your eye health and vision needs.

Patient/Guardian Signature: ____ Date: ____________________

I have reviewed last year's Patient Information Form and have initialed / dated next to any changes from my previous visit or I have found no changes to the previous visit and have initialed below.

Initial – Date: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Arvada Optometric Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read, had the opportunity or had explained to me Arvada Optometric Center's Notice of Privacy Practice.
- I understand that by NOT signing this form. I can NOT be seen at Arvada Optometric Center as a patient.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

__________________________________ __________________

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

____________________________ ______________________

Representative Relationship to Patient