OmniVision Eye Care / Lighthouse Eye Care

New Patient Form

First Name: __________________ Last Name: DOB: _____/____/_____

Email: ______________________@__________**.com**

How did you hear about us? __Insurance __Walk in ___advertisement __ Google search __ Lighthouse website

__another doctor, Dr. ___________________ __friend/family__________________________

FOR OUR PATIENTS WITH INSURANCE COVERAGE

INSURANCE COVERAGE MUST BE VERIFIED BEFORE TESTING CAN BEGIN

As a service to our patients, we do our best to verify medical and vision insurance benefits. However, we are not responsible for incorrect benefit information given to us by your insurance company regarding insurance coverage, allowances, co-pays, or other information needed to file an insurance claim. In the event the insurance carrier determines that you are not eligible for coverage at the time of service or makes a determination you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any charges incurred by you and not paid by your insurance provider.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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

I have been offered and/or reviewed the Notice of Privacy Practices which explains how my medical information will be used or disclosed.

I understand I am entitled to receive a copy of the Privacy Practices.

I authorize release of medical information to any physician involved in my care and insurance companies involved in the payment of services rendered on my behalf.

I acknowledge the Office may send me important information through email and text messages.

MEDICAL INFORMATION AUTHORIZED USERS

I authorize Lighthouse Eye Care to release all medical information to my family members and friends listed below.
I may revoke this authorization in writing at any time.

NAME____ **RELATIONSHIP** _____________________________

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Optomap: Optomap widefield imaging allows the doctors to review the internal health of the eye without the need for routine eye dilation.

The doctors do highly recommend this test to provide the best care. The copay is $39.

Contact Lens Follow up Policy – *please read and acknowledge*

1. All professional fees are due and payable at the time of service and are non-refundable.

For our patients who will be fitted for contact lenses

1. The contact lens evaluation fee covers only visits related to the fit of the contact lens. Fit related issues may include the comfort of the lens and the visual acuity achieved with the lens. Fit related issues DO NOT include, and are not limited to red eye associated with or without contact lens wear, scratched corneas from lens insertion/removal or torn lens, contact lens solution sensitivity, contact lens lodged in the eye, or dry eyes, etc.
2. Any follow up visit due to the fit of the contact lens will be covered by the contact lens fee, up to 3 follow up visits. Any follow up visit after the 3rd follow up visit or after 45 days, will be charged the appropriate professional fee. **Therefore, it is important to keep all follow up visits to achieve the optimal contact lens fit within the 45 day global period.** *If you are using insurance, the contact lens follow policy set forth by your insurance company will be used.*

I acknowledge that I have received, read, and agreed to the policies listed above

_______________________________________ _________

Patient / Guardian signature **Date**

MEDICAL HISTORY

REVIEW OF SYSTEMS (please check any condition you currently have)

GENERAL: □ Fever □ weight loss □ weight gain □ fatigue
EAR, NOSE, THROAT: □ Allergies □ sinus □ cough □ dry mouth/throat □ loss of hearing
CARDIOVASCULAR: □ high blood pressure □ heart surgery □ vascular disease
GASTROINTESTINAL: □ acid reflux □ intestinal problems □ liver problems
GENITOURINARY: □ Impotence □ kidney disease □ bladder disease
MUSCLES/BONES/JOINTS: □ arthritis □ muscle/joint pain □ head/neck injury
BLOOD / LYMPH: □ Anemia □ bleeding disorder □ high cholesterol
NEUROLOGICAL: □ headaches □ migraines □ seizures □ numbness
RESPIRATORY: □ Asthma □ bronchitis □ COPD
ENDOCRINE: □ Diabetes □ thyroid disease
INTEGUMENTARY (SKIN): □ growths □ rashes □ acne
FEMALES: □ Pregnant: ______months □ Trying to get pregnant □ Nursing
IMMUNOLOGIC: □ HIV/AIDS □ allergies □lupus
PSYCHIATRIC: □ Depression □ anxiety insomnia

Patient Ocular History (please check all that applies)

□ Blindness □ Glaucoma □ lazy Eye □ Eye infections
□ Turned Eye □ Trauma □ Cataracts □ Poor color vision
□ Amblyopia □ Retina disease □ Visual blackouts
□ Eye Surgeries: ____
□ Other:____

Medical History (please check all that apply)

□ Diabetes □ Thyroid disease
□ Hypertension □ Arthritis
□ High Cholesterol □ Depression
□ Seasonal allergies □ Migraines
□ Other________________________________

OCULAR MEDICATIONS (*PLEASE PRINT*)

* Please list any EYE DROPS you are using (include ***over the counter eye drops***): ________________________________

SYTEMIC MEDICATIONS (*PLEASE PRINT*)

* Please list all medications you are taking and **what you are taking them for** (include oral contraceptives, ***over the counter medications***, vitamins, home remedies):

* **Do you have any drug allergies**: ____

*** Primary Care Physician:**________________________________ **Phone:**____________________

FAMILY EYE HISTORY

Glaucoma	□ **Y**	□ **N**	____________
Macular Degeneration	□ **Y**	□ **N**	____________
Lazy eye/Eye turn	□ **Y**	□ **N**	____________
Blindness	□ **Y**	□ **N**	____________
Retinal Detachment	□ **Y**	□ **N**	____________
Other Eye Disease	□ **Y**	□ **N**	____________

FAMILY MEDICAL HISTORY

Cancer	□ **Y**	□ **N**	____________
Diabetes	□ **Y**	□ **N**	____________
Hypertension	□ **Y**	□ **N**	____________
Heart Disease	□ **Y**	□ **N**	____________
Others	□ **Y**	□ **N**	____________

SOCIAL HISTORY

Occupation: ______________________________ How many hours a day do you spend on the computer? __________
Employer/School: __________________________ Do you Smoke? □ **Y** □ **N** Do you drink alcohol? □ **Y** □ **N**
Do you currently drive? □ **Y** □ **N** **If yes, do you have difficulties driving?** ______________________
Do you play sports or engage in outdoor activities? □ **Y** □ **N** **If yes, please list:** ______________________
Hobbies: ____

Optical History

What is your primary vision correction? □ **Glasses** □ **Contacts** □ **Both** Do you wear sunglasses? □ **Yes** □ **No**
Age of Current glasses: ____ years Do you plan on purchasing new glasses today? □ **Yes** □ **No** □ **Yes, If recommended**
Do you want to be evaluated for contact lenses today? □ **Yes** □ **No**

If you are currently wearing contacts:

How often do you dispose of you contacts? ______________ How many hours a day do you wear contacts? ______________
What contact lens solution do you use? □ **OptiFree** □ **Clear Care** □ **Renu** □ **Generic** □ **Other**__________________
How many days out of the week do you wear your contacts? ______________
Do you sleep overnight in your contacts? □ **Yes, how many days?** ________ □ **No** **Do you have backup glasses?** □ **Yes** □ **No**

____

Patient / Guardian signature **Date**