Aspire Eye Care

Dr. Annie Quach

Date ______________________

PATIENT INFORMATION

______________ (First) ______________ (Last) _____ (M.I.) **DOB** ___/___/____ **Age** ____ **Sex** ☐ Male ☐ Female

Address ______________ **City** ______________ **State** ______ **Zip** ________

Phone # ______________ (cell/work/home) **Secondary phone #** ______________ (cell/work/home)

Occupation ______________ **Employer** ______________ ☐Single ☐Married ☐Divorced ☐Widowed

Email ______________ **Whom may we thank for referring you?** ______________

Parent/Guardian's name if patient is under 18 years of age ______________

INSURANCE INFORMATION

Vision insurance ______________ **Group#** ______________ **ID#** ______________

Medical insurance ______________ **Group#** ______________ **ID#** ______________

Policy holder ______________ **Relationship to patient** ______________ **Policy holder's birth date** ______________

Policy holder's SSN ______________ **Patient's SSN** ______________

OCULAR/MEDICAL HISTORY

Reason for today's visit: ☐Glasses ☐Contacts ☐Medical office visit ☐Other: ______________

Last eye exam ________ **Last medical exam** ________ **Primary care physician** ______________

Do you wear glasses? ☐Yes ☐No **Type:** ________ **How old are your present glasses?** ______________

Do you wear contacts? ☐Yes ☐No **Type:** ☐Soft ☐Hard **Brand** ______________ **Power** ______________

Are you currently experiencing any of the following? Please check all that apply.

☐Blurred vision ☐Redness ☐Eye strain ☐Flashes of light ☐Light sensitivity ☐Tearing

☐Double vision ☐Dry eye ☐Burning ☐Itching ☐Floaters/Spots ☐Eye pain

Have you or any of your immediate family members been diagnosed with any of the following? Please check all that apply.

	Self	**Family**		**Self**	**Family**
Amblyopia / lazy eye	☐	☐	Diabetes	☐	☐
Blindness	☐	☐	High blood pressure	☐	☐
Crossed eyes	☐	☐	High cholesterol	☐	☐
Cataracts	☐	☐	Thyroid disease	☐	☐
Glaucoma	☐	☐	Heart disease	☐	☐
Macular degeneration	☐	☐	Cancer	☐	☐
Eye injury / infection	☐	☐	Arthritis	☐	☐
Retinal disease	☐	☐	Lung disease / Asthma	☐	☐

Other: ______________

Please list all **major eye surgeries and other surgeries** you have had (include dates):

____

Please list all **medications** you take (including eye drops, birth control, over-the-counter medications, and vitamins):

____

Please list any **allergies** you have (including medications):

____

Do you use tobacco? ☐ Yes ☐ No If yes, amount and for how long ______________

Do you drink alcohol? ☐ Yes ☐ No If yes, how often ______________

Do you use recreational drugs? ☐ Yes ☐ No If yes, type / amount / for how long ______________

Are you currently pregnant or nursing? ☐ Yes ☐ No If yes, how many months ______________

AUTHORIZATION

I certify that I have read and understand the information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the optometrist to release any information including the diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such eye care to third party payers and/or health practitioners. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies and I request my insurance company to pay directly *Aspire Eye Care, LLC*. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that all visits to this office are payable at the time of service. I authorize payment directly to my doctor. **I understand that all examination fees and copayments are due when service is rendered and are NON-REFUNDABLE.**

EXAMINATION POLICY

If necessary, you will have 60 days from your last complete exam date for a glasses prescription re-check at no cost. All contact lens services are separate from the routine eye exam. By law in Texas, contact lens prescriptions are valid for one year. Disposable trial lenses are for fitting purposes only and <u>will be dispensed only at the initial fitting examination</u>**.** This ***excludes*** any contact lens upgrades ***OR*** medical problems, which will be billed accordingly. You have 60 days from the initial exam date to return for a contact lens upgrade in which you will be responsible for paying the difference in fees. Once the contact lens prescription is finalized, we reserve the right to charge additional fees for any contact lens re-fits or upgrades.

CONTACT LENS AGREEMENT

Contact lens wear can improve the quality of life but also poses some risks and limitations. You must take proper care of your lenses and know what to do in the event of a problem. It is essential that you follow instructions as directed by your optometrist to avoid any potential risks. As with prescription medications, contact lenses can only be dispensed pursuant to a prescription by an eye care practitioner with a limit on the supply of lenses to be purchased before an expiration date. Your optometrist will recommend a specific wearing, replacement and follow-up schedule. **Remove** your contact lenses and call our office **immediately** if you experience any of the following symptoms: eye pain/irritation, sensitivity to light, eye redness, stinging, burning, excessive tearing, discharge, blurry vision or disturbance of vision.

I have read this document carefully and fully understand the importance of the Doctor's recommendations. The contact lens examination fee covers all routine follow-up visits for no additional charge for **<u>60 DAYS</u>** after your full exam. Additional examination after 60 days of the initial contact lens examination will result in an additional charge of $25.00 **per visit.**

ACKNOWLEGEMENT OF PRIVACY PRACTICES

I acknowledge that I have read and understand the Notice of Privacy Practices. I understand that this office is HIPPA compliant. I hereby acknowledge that the HIPPA policies are posted and available for me to read.

By signing below, I agree that I have read the above and consent to the use and disclosure of my health information for purposes of treatment, payment and health operations. I understand I am financially responsible for all charges incurred by myself and/or my dependents.

Patient or Parent/Legal Guardian Signature: ______________________________ Date: ________________