OPTIMUS
EYE CARE

Date: _____
Legal Name (Print): _____ DOB_____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____ **CELL / HOME** Number:_____
Gender: **M / F** Occupation: _____ Referred By:_____
Race: **AMERICAN INDIAN / ASIAN / AFRICAN AMERICAN / PACIFIC ISLANDER / HISPANIC / LATINO / WHITE / OTHER**

PATIENT HEALTH HISTORY

What is the main reason for your visit today? (Circle all that apply)

ANNUAL EXAM **GLASSES** **CONTACT LENS** Other (explain):_____

I have noticed a blur in vision **WITH** or **WITHOUT** glasses/contacts at: **DISTANCE** **READING** **NO BLUR**

Wear **glasses? Y / N** If so, do you wear **FULL TIME** or **AS-NEEDED**

Wear **contacts? Y / N** If so, Brand:_____ Solution: _____ Sleep in them? **Y / N**

Medical/Family History

Please list **current MEDICATIONS**:

_____

_____

List **medications or eye drops you are ALLERGIC to**:

_____

Women – Are you pregnant? **Y / N** If so, how many weeks pregnant? _____

Disease/Condition	Yourself	Year Dx	List **Parents or Siblings w/ condition** or **[ADOPTED]**
Diabetes	**Y / N**	_____	_____
Hypertension	**Y / N**	_____	_____
High Cholesterol	**Y / N**	_____	_____
Thyroid Disorder	**Y / N**	_____	_____
Cataract	**Y / N**	_____	_____
Cataract Surgery	**Y / N**	_____	_____
Macular Degeneration	**Y / N**	_____	_____
Glaucoma	**Y / N**	_____	_____
Retinal Detachment	**Y / N**	_____	_____
Eye that Turned In or Out	**Y / N**	_____	_____
Eye Turn Surgery	**Y / N**	_____	If so, which eye? **R / L / BOTH**
Eye Injury	**Y / N**	_____	If so, which eye? **R / L / BOTH**
LASIK Surgery	**Y / N**	_____	If so, which eye? **R / L / BOTH**
Seasonal Allergies	**Y / N**		

Social Cigarette Use: **NEVER SMOKED / CURRENT SMOKER / FORMER SMOKER**

Review of Systems: Please indicate below **(circle condition(s))** if you have any of the following:

Cardiovascular	Psychiatric	Ear, Nose, Throat	Respiratory	Neurological
Stroke	Depression	Sinus infection	Asthma	Headaches
Heart Attack	Bi-Polar	Deaf (partial or full)	Emphysema	Migraines
Congestive Heart Failure	Anxiety		COPD	Multiple Sclerosis
Pacemaker	ADHD			Seizure
Irregular Heart Beat	ADD			Epilepsy

Integumentary	Gastrointestinal	Musculoskeletal	Genitourinary	Hematologic
Dermatitis	Hepatitis	Arthritis	Kidney Disorder	Anemia
	Acid Reflux		Bladder	Prostate

If you have a condition not listed above, please explain:

_____

_____

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Office Policy

- All office visits are due and payable at the time of service.
- Each visit to the office is a separate office visit and a co-payment or office visit fee will apply and is due and payable at the time of service.
- All fees are non-refundable.
- If for any reason you are unable to keep your appointment, please contact our office 24 hours before your scheduled appointment if possible. Optimus Eye Care reserves the right to charge a no show fee if you do not call us 24 hours in advance.
- Contact lens prescriptions for new patients to the office may only be released after a contact lens follow up examination has been completed.
- An office visit fee will apply if it has been over 30 days since your initial examination.
- A full contact lens examination fee will apply if it has been over 60 days since your initial examination.
- Glasses and contact lens prescriptions are valid for one year after the date of the initial examination.
- There is $10 administrative fee for copies of the whole exam records. Additional charges may apply if records are mailed. The records will be released by the end of the next business day once record is located. A medical release form may need to be completed in order to release any records.

Method of Payment: **Please check one.**

Cash: _____ **Credit/Debit/FSA/HSA Card: _____**

Insurance Policy

- I authorize Optimus Eye Care to use and release my insurance information in order to verify my eligibility and/or benefits as well as to submit insurance claims.
- I authorize Optimus Eye Care to act as my agent in helping me obtain payment from my insurance company.
- I understand that I am fully responsible for my bill if the insurance does not pay Optimus Eye Care.
- I authorize payment directly to Optimus Eye Care and Dr. Khuat.
- I permit a photocopy or fax of this authorization to be used in place of the original.
- All patients who are using their insurance must have a valid insurance card present and photo ID if asked for identification.
- Some insurance plan guidelines require a referral when seeing a specialist. If your plan requires this, please be sure to have a valid referral prior to coming for your appointment. If you do not have a valid referral at the time of your appointment, it may be necessary to reschedule.
- We are happy to bill your services to any plan with which we have a contract.
- Patients who do not currently carry insurance, or are covered through a plan other than those that Optimus Eye Care is contracted with, will be required to make a full payment at the time of service. We will gladly provide you with the necessary paperwork for you to submit a claim to your insurance carrier.

I understand that I am financially responsible for any charges at Optimus Eye Care incurred by myself or any of my dependents, and I have also read and understand the above office and insurance policies.

Signed: _____ **Relationship to Patient: (Circle one)** **Self / Mother / Father / Guardian** **Date: _____**

I acknowledge that I have been offered to read the copy of Optimus Eye Care's Notice of Privacy Practices (HIPAA).

Signed: _____ **Date: _____**