Patient Form

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Cell Phone	Home Phone

Email

Preferred Contact Method *Cell Phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Patient Date of Birth	Male/Female

Occupation/Employer	*Full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language

Race *White* | *Asian* | *American Indian/Alaska Native* | *Black/African American* | *Native Hawaiian/Pacific Islander* | *Decline*

Ethnicity *Hispanic or Latino* | *Not Hispanic or Latino*

Emergency Contact Person and Phone

INSURANCE INFORMATION

Primary Medical Insurance

Member Name

Insurance ID#	Insurance Policy#/Group ID#
Member Date of Birth	Member Social Security Number

Member Employer

Patient relationship to member *self* | *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Member Name

Insurance ID#	Insurance Policy#/Group ID#
Member Date of Birth	Member Social Security Number

Patient relationship to member

Vision Insurance *(list all if applicable)*

Member Name	Primary Member Date of Birth

Insurance ID#

Primary Care Physician Name and Phone

Patient Form

EYE HISTORY

Date of Last Exam		
Currently Wear Glasses?	*Yes*	*No*
Currently Wear Contacts?	*Yes*	*No*
Brand if Yes:		
Any Eye Surgery? List		
Reason for today's visit		

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	Yes	No	Family
Crossed Eye	Yes	No	Family
Glaucoma	Yes	No	Family
LAZY Eye	Yes	No	Family
Macular Degeneration	Yes	No	Family
Retinal Detachment	Yes	No	Family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ○ Blurry Vision — *near or distance*
- ○ Burning
- ○ Discharge
- ○ Double Vision
- ○ Dryness
- ○ Excess Tearing/Watering
- ○ Eye Infection
- ○ Eye Infection
- ○ Eye Pain or Soreness
- ○ Floaters or Spots
- ○ Halos
- ○ Headaches
- ○ Itching
- ○ Light Flashes
- ○ Light Sensitivity
- ○ Redness
- ○ Sandy or Gritty Feeling

NOTES/ADDITIONAL INFORMATION

MEDICAL HISTORY

Have you or a family member experienced or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*Yes*	*No*	*Family*
Allergies	*Yes*	*No*	*Family*
Arthritis	*Yes*	*No*	*Family*
Stroke	*Yes*	*No*	*Family*
Thyroid Dysfunction	*Yes*	*No*	*Family*
Asthma	*Yes*	*No*	*Family*
Blood/Lymph Disorder	*Yes*	*No*	*Family*
Skin Conditions	*Yes*	*No*	*Family*
Cancer	*Yes*	*No*	*Family*
Diabetes	*Yes*	*No*	*Family*
Ears, Nose, Throat Conditions	*Yes*	*No*	*Family*
Gastrointestinal Conditions	*Yes*	*No*	*Family*
Heart Disease	*Yes*	*No*	*Family*
High Blood Pressure	*Yes*	*No*	*Family*
High Cholesterol	*Yes*	*No*	*Family*
Kidney Disease	*Yes*	*No*	*Family*
Lupus	*Yes*	*No*	*Family*
Neurological Conditions	*Yes*	*No*	*Family*
Psychiatric Disorder	*Yes*	*No*	*Family*
Seizures	*Yes*	*No*	*Family*

Current Medications (prescription and over the counter and dosage)

Medication Drug Allergies

Height	**Weight**		
Are you Pregnant or Nursing?	*N/A*	*Yes*	*No*
Do you smoke?		*Yes*	*No*
Have you ever smoked?		*Yes*	*No*

Patient Form

REFRACTION POLICY AND FINANCIAL RESPONSIBILITY AGREEMENT

Most medical plans, including Medicare, do not cover refractions or routine eye examinations (when NO medical eye problem is known or suspected). If your examination includes refraction, there will be a $30.00 additional fee, since it is not a covered service.

I HEREBY AUTHORIZE THIS OFFICE TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED. I THROUGHLY UNDERSTAND THAT MY INSURANCE IS AN AGREEMENT BETWEEN THE INSURANCE PROVIDER AND MYSELF, NOT BETWEEN THE INSURACE PROVIDER AND THE MEDICAL OFFICE. IF AUTHORIZATION IS REQUIRED FROM MY PRIMAY CARE PHYSICIAN, I HAVE TO OBTAIN SUCH DOCUMENT(S) PRIOR TO MY VISIT. I THEREFORE AGREE THAT THE PAYMENTS FROM INSURANCE COMPANIES BE MADE TO OPTOMETRIC CONSULTANTS OF VIRGININA, INC. (d.b.a. Eye & Vision Care). I ALSO UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR MY MEDICAL SERVICES RENDERED. I CERTIFY THAT INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. I AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL RECORDS, TO DETERMINE INSURANCE BENEFITS TO WHICH I MAY BE ENTITLED.

Patient, Parent or Guardian's Signature   Date

INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctors at Optometric Consultants of Virginia, Inc. d.b.a Eye & Vision Care to get a better view of the inside of your eye.

Dilating drops blurs the near vision. It does not affect the distance vision but light sensitivity can make driving difficult afterwards. It is not possible for your optometrist to predict how much your vision will be affected. You may need driver afterwards.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Dimple Kapoor, O.D and/or associates, or such assistants as may be designated by her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient, Parent or Guardian's Signature   Date

NOTICE OF PRIVACY PRACTICES

Our notice of privacy practice provides information about how we may use and disclose protected health information (PHI) about you. The notice contains patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we Change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient, Parent or Guardian's Signature   Date