NIPOMO OPTOMETRY
MEMBER
VISION SOURCE NETWORK

Welcome to Our Office!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Date: _____

Patient Information

Last: _____

First: _____ **MI:**_____

Street: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

How so you prefer to be contacted?
(Indicate #1 and #2 preferences)

Home # ____ **Work #** _____ **Cell #** _____ **Text** _____ **Email** _____

Patient Information

Patient's SSN: _____

Date of Birth: _____ **Age:** _____

Sex: M F **Race:** _____

Ethnicity: _____

Employer: _____

Occupation: _____

Spouse (Or parent's) Name: _____

Spouse (Or parent's) Work: _____

If not referred, how did you choose our office?

_____

Do you participate in a Flex Spending Account?

Yes _____ **No** _____

Appointment Survey

We value you as a patient and appreciate you choosing us as your eye care provider!

We have found that many people looking for an eye doctor rely on reviews to help them find an office that best suits their needs. For that reason, would consent to us sending you a brief post appointment survey? Yes [ ] No [ ]

We'd love you to tell others about us!

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Patient Medical History Form

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Family Medical / Eye History

Do you have a family medical history of any of the following?

(Please specify who):

Blindness	☐_____
Cataracts	☐_____
Corneal Problems	☐_____
Diabetes	☐_____
Glaucoma	☐_____
Heart Disease	☐_____
Lazy Eye	☐_____
Macular Degeneration	☐_____
Retinal Problems	☐_____

Lifestyle Questions

Do you… (Check all that apply):

☐…use a phone, computer, tv, or tablet on a regular basis? If yes, how many hours per day? _____hrs/day
☐…think you might benefit from thinner, lighter lenses?
☐…prefer NOT to wear glasses at times?
☐…spend time outdoors? How often? ____hrs/week
☐…participate in sports or other activities? Hobbies?

If yes, please specify:

_____

_____

_____

Patient Eye History

Date of Last Eye Exam: _____

By Whom? _____

Have you had any eye-related surgeries of any kind?
☐Yes ☐No

Have you ever experienced, been diagnosed or treated for any of the following?

☐Blurry Vision	**☐Burning**
☐Cataracts	**☐Corneal Abrasions**
☐Crossed eye/Eye turn	**☐Double Vision**
☐Eye Infections	**☐Eye Injury**
☐Flash of light	**☐Floaters/Spots**
☐Glaucoma	**☐Grittiness**
☐Headaches	**☐Iritis/Uveitis**
☐Itchiness	**☐Lazy Eye**
☐Macular Degeneration	**☐Occasional dryness**
☐Retinal Detachment	**☐Sunlight Sensitivity**
☐Tearing	**☐Trouble seeing at night**
☐Uncomfortable glasses	

☐Other eye disorders: _____

Continued on next page…

Patient Medical History Form, Continued…

Patient Medical History

Name of Primary Care Physician: _____

Address: _____

Phone: _____

Date of Last Physical Check-Up: _____

Height:_____**Weight:**_____

Pharmacy: _____

Address: _____

Phone: _____

Current Medications (Rx or Over-The-Counter)

(List name of medications, including eye drops, vitamins & birth control pills, dosages, and frequency. Please bring a list if possible!

_____

_____

_____

_____

_____

Allergies to medications? ☐**Yes** ☐**No**

If so, what medications? _____

_____

_____

Do you use cigarettes/tobacco, alcohol, or other substances?

☐**Yes** ☐**No**

If so, how often?

_____

_____

Patient Medical History, Continued

Have you ever been *diagnosed* or *treated* for the following health problems?

PLEASE SPECIFY Diagnosis along the line provided

Allergies	**Y**	**N**	_____
Arthritis	**Y**	**N**	_____
Blood/Lymph	**Y**	**N**	_____
Bronchitis	**Y**	**N**	_____
Cancer	**Y**	**N**	_____
Cholesterol	**Y**	**N**	_____
Diabetes	**Y**	**N**	_____
Digestive	**Y**	**N**	_____
Ears/Nose/Throat	**Y**	**N**	_____
Endocrine	**Y**	**N**	_____
Eczema/Rashes	**Y**	**N**	_____
Fatigue	**Y**	**N**	_____
Fevers	**Y**	**N**	_____
Genitourinary	**Y**	**N**	_____
High Blood Pressure	**Y**	**N**	_____
Integumentary (Skin)	**Y**	**N**	_____
Kidney	**Y**	**N**	_____
Muscle/Bone	**Y**	**N**	_____
Neurological	**Y**	**N**	_____
Psychological	**Y**	**N**	_____
Respiratory	**Y**	**N**	_____
Sinus	**Y**	**N**	_____
Throat Infections	**Y**	**N**	_____
Thyroid	**Y**	**N**	_____

MEDICATION LIST

- _____ **Dose**_____
- _____ **Dose**_____
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- **VITAMINS** •

- _____ **Dose**_____
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- _____ **Dose**_____

SPEED Questionnaire

Name:_____, _____ **Date:**___/___/____

DOB:___/___/_____ **Sex: M F (Circle)**

How FREQUENTLY do you experience the following dry eye symptoms?

Symptoms	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

How SEVERE are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

For office use only
Total SPEED score (Frequency + Severity) =_____/28

How would you rate your overall dry eye symptoms on a scale from 0-10, with 10 being the worst?

0 1 2 3 4 5 6 7 8 9 10

Contact Lens Care Agreement

Contact Lenses are FDA class II medical devices that have the potential for serious complications if not used and fitted properly. For that reason, the standard of care and the requirements of the California State Board of Optometry require annual examinations for renewal of a contact lens prescription. In addition to general eye health assessment, the doctor will assess issues related to contacts such as; abnormal blood vessel growth, corneal damage, chronic inflammation, hygiene, discomfort, and poor surface compatibility, along with any vision changes. The Contact Lens Management Fee covers any lens related follow ups for a 90 day period. If you cannot complete the fitting procedure in the allotted time due to missed follow up appointments, there will be an additional $50 charge per visit beyond the global time period.

Contact Lens Management Fees

NEW WEARERS

Tier I Spherical	**$120.00**
Tier II Toric	**$130.00**
Tier III Multifocal/Monovision	**$150.00**
Tier V Gas Permeable Lens	**$120.00**
Tier VI Gas Permeable Lens – Complex/Medical	**$300.00**

ESTABLISHED WEARERS:

Tier I Spherical Lens	**$60.00**
Tier II Toric Lens	**$70.00**
Tier III Multifocal/Monovision	**$80.00**
Tier IV New Patient, OR Established wearer without current rx	**$100.00**
Tier V Gas Permeable Lens	**$120.00**
Tier VI Gas Permeable Lens – Complex/Medical	**$300.00**

Contact Lens Questionnaire:

What type of lenses do you currently wear? Spherical Toric Multifocal Monovision

Contact Lens Brand : _____ Solution Name: _____

Can you see both distance and near comfortably with your contact lenses? Y N

How many days a week do you wear your contacts? _____

Do you sleep overnight in your contacts? Y N

If yes, how many nights per week? _____

Do you experience dryness with your contacts? Y N

Do you have a backup pair of glasses? Y N

How often do you change your contact lens case? _____

How often do you change your contacts? _____

Please rank the following from least to most important; (1= Most important, 4 = Least Important):

_____ Convenience _____ Comfort _____Clarity _____Cost

By signing I acknowledge that I understand the policies regarding the fitting of contact lenses and agree to the associated fees. I understand that these fees are an estimate and are subject to changes based on the doctor's final assessment. I also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage. I understand that if an infection is present, I will need to be treated under my medical insurance prior to being refit with contact lenses.

Signature: _____ Date: _____

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health Information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without any written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of the other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- I received notification that the staff at Nipomo Optometry will have access to my claims medication history through an electronic service until I revoke my consent. I understand that my consent can be revoked at any time. Revocation must be made in writing.
- My individual rights with respect to protect health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of Health and Human Services (HHS) if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information.
    - The right to inspect and copy protected health information.
    - The right to receive and accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make the new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Payment Policy

I hereby assign all medical benefits to which I am entitled including Medicare, private insurance and any other health plans, to Nipomo Optometry. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Nipomo Optometry within 60 days, I may be billed for any services or products that I have received. I certify that my responses on this form are accurate to the best of my knowledge. I certify that I understand cancellations on eyeglasses are not permitted as all eyeglasses are custom crafted for each patient with their unique prescription. *I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs.*

Signature: _____ Date: _____