eye carumba
OPTOMETRY

PATIENT INFORMATION AND HISTORY

First Name _____ Last Name _____ M.I. _____ Nickname _____

Age _____ Gender _____ Type of Insurance _____ Date of Birth _____

Occupation _____ Where did hear about us? _____

Street Address _____ City _____ State _____ Zip _____

Email address: _____

(_____) _____ Preferred method of contact: ○ e-mail ○ phone
Day Phone

_____ (_____) _____ _____
Emergency contact Phone Relationship

I have ○ been seen ○ not been seen at Eye Carumba Optometry before. Reason for today's visit:

Vision History

Date of most recent eye exam: _____ Doctor: _____

Do you wear glasses? ○ Yes ○ No How old is your current prescription? _____

Do you wear contacts? ○ Yes ○ No What type of contacts? _____

Do you work with computers? ○ Yes ○ No If yes, please complete Computer Vision Questionnaire.

Please indicate any of the following that apply to you or members of your family:

Ocular Health:	Me	Family		Me	Family
Cataracts	☐	☐	Crossed/Lazy Eye	☐	☐
Eye Surgery/Injury	☐		Glaucoma	☐	☐
Macular Degeneration	☐	☐	Retinal Detachment	☐	☐

General Health:	Me	Family		Me	Family
Arthritis	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Heart Problems	☐	☐
High Blood Pressure	☐	☐	HIV	☐	
Kidney Disease	☐	☐	Lung/Respiratory Disease	☐	☐
Thyroid Disease	☐	☐	Liver Hepatitis	☐	☐
High Cholesterol	☐	☐			

Personal Health:

Allergies: _____ Drug Sensitivities: _____

WOMEN: Pregnant ○ No ○ Yes Due: _____ Nursing: ○ No ○ Yes

Headaches: _____ Other Medical Conditions: _____

Please indicate all medications you are currently taking:

Medication: _____ Dosage :_____ For:_____

Medication: _____ Dosage :_____ For:_____

Medication: _____ Dosage :_____ For:_____

How is your overall health? ○ Excellent ○ Good ○ Fair ○ Poor

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COMPUTER VISION QUESTIONNAIRE

1. Indicate time spent:
   a. On a computer at work: _____ hours per day
   b. On a computer at home: _____ hours per day
   c. On a handheld device (e.g., Blackberry): _____ hours per day

2. Desktop or laptop computer Use: (check applicable)

   My work computer is a: ◯ desktop ◯ laptop My home computer is a: ◯ desktop ◯ laptop

3. Lighting in work area: (please describe)

   Overhead/desk: _____

   Incandescent/ fluorescent: _____

4. Are you experiencing any of the following symptoms while at your computer monitor?

   Check where appropriate

   ☐ Headaches
   ☐ Blurred distant vision
   ☐ Back pain
   ☐ Sore or tired eyes (eye strain)
   ☐ Dry or watery eyes
   ☐ Neck and shoulder pain
   ☐ Blurred near vision
   ☐ Burning, itching, or red eyes
   ☐ Double vision
   ☐ Glare (light) sensitivity

5. Do you wear glasses while working at the computer?

   ◯ Yes ◯ No (If yes, please bring them with you to your eye exam.)

6. Do you wear contact lenses while working at the computer?

   ◯ Yes ◯ No (If yes, please wear them for your eye exam.)

7. Do you view reference material while working at the computer?

   ◯ Yes ◯ No (If yes, what percentage of time? _____)

8. Viewing distance (eye to computer screen) is _____ inches.

9. Viewing distance (eye to keyboard) is _____ inches.

10. Viewing distance (eye to reference material) is _____ inches.

11. The center of the computer screen is: (check one)

    ◯ above eye level ◯ equal to eye level ◯ below eye level

    If above or below, by how many inches? _____

12. Reference material is: (check one)

    ◯ above eye level ◯ equal to eye level ◯ below eye level

    If above or below, by how many inches? _____

Is there anything else you would like your doctor to know about your health?

Social History

Do you participate in any sport, hobby, professional activities that may require special protection or correction (for example: squash/handball, scuba, reading music, carpentry)?

Do you use tobacco? ○ Yes ○ No What type/Amount/How long? _____

Do you drink alcohol? ○ Yes ○ No What type/Quantity/Frequency? _____

CANCELLATION POLICY

Appointment cancellations made less than 24 business hours prior to your scheduled appointment will result in a $50 cancellation charge. This is an out-of-pocket fee that will not be paid by your insurance company.

PAYMENT POLICY

Payment for services is requested at the time services are rendered. For materials ordered, a 50% deposit is required at the time of ordering, with the balance due on delivery. If our policies pose a financial burden, please ask to speak privately with the Office Manager.

It is the responsibility of the patient to know and understand their vision insurance benefits. The patient agrees to be responsible for all fees not covered by their vision or medical insurance plan.

RETURN POLICY

Professional Services:

Fees for professional services are non-refundable.

Glasses/Ophthalmic Products:

Glasses are complex, custom-made medical devices comprised of a set of frames and spectacle lenses. In the event that a patient is not satisfied with the visual acuity obtained with the prescription lenses provided by Eye Carumba Optometry, the patient will be asked to return to the office for an adjustment of the glasses and, as necessary, schedule a short prescription check appointment with the doctor. Eye Carumba Optometry makes every effort to provide glasses that are accurate to the prescribing doctor's instructions.

This process must be initiated within 90 days of the original purchase date. Returns and refunds are considered by the office management on a case-by-case basis. Restocking fees may apply.

Contact Lens Purchases:

In the case of a prescription change for contact lenses, you may return or exchange unused contact lenses purchased within one year of the original purchase date. Merchandise must be in the original, unopened packaging. All merchandise must be in like-new condition and accompanied by the original receipt.

_____ _____

Signature Date

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CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

_____

First Name Last Name M.I

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes submission of your health information to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you authorize us to use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time, unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Signature Date

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____

Name Relationship to patient

_____

Source of Authority