THE EYE STUDIO
eyecare + eyewear

DATE_____

LAST NAME_____

FIRST NAME_____MIDDLE INITIAL_____

NICK NAME_____

TITLE: ☐ Mr. ☐Mrs. ☐Miss ☐Dr.☐ Capt. SEX: ☐M ☐F

SSN_____

Age _____ **Patient Birth Date**_____

Address_____

City_____ **ST** ____ **ZIP**_____

Cell#_____

Home# _____

Email_____

Employer_____ ☐Retired

Occupation_____

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Race: ☐ American Indian or ☐ Alaska Native ☐ Asian
☐ African American ☐ Caucasian ☐ Hispanic
☐ Native Hawaiian or Other Pacific Islander
☐Other_____

Ethnicity: ☐ Not Hispanic or Latino ☐Hispanic or Latino
☐Native Hawaiian or Other Pacific Islander

Preferred method of communication: ☐Phone ☐Text ☐Email

Person legally and financially responsible for patient:

_____

Person's relationship to the patient: _____

How did you hear about us: ☐Walk in ☐Internet ☐ Insurance

☐ Instagram ☐Facebook ☐Patient referral ☐DR. referral

If referred, name of patient or Doctor: _____

PLEASE ENTER YOUR INSURANCE INFORMATION

VISION Insurance_____

Member ID _____ Group# _____

MEDICAL Insurance _____

Member ID_____ Group# _____

Insured's (Primary) Name_____ ☐Self

Birth Date _____SS#_____

(SELF PAY & INSURANCE) ASSIGNMENT AND RELEASE

I certify that I and/or my dependents have insurance coverage with the above-named company(ies). By signing below, I authorize payment of insurance benefits be made on my behalf to Dr. Mona Patel OD, LLC for services rendered. I understand that I am financially responsible for all items not paid by my insurance company FOR ANY REASON. I hereby authorize the doctor to release any information needed to Secure payment of benefits.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

MEDICAL HISTORY

REASON FOR TODAY'S VISIT: _____**Time since last exam**: _____Years _____ Months

Are you requesting a Contact Lens Exam/Fit today? ☐ Yes ☐No

Do you currently wear contact lenses? ☐ Yes ☐No If Yes, Type of contacts: ☐Soft ☐Rigid ☐Astigmatism / Toric ☐Multifocal

If Yes, Current Brand:_____ Current Prescription _____

Are you planning to purchase eyeglasses today? ☐Yes ☐ No Are you planning to purchase contacts today? ☐Yes ☐No

List your allergies to medications or other substances (including latex) _____

List any eye injuries and surgeries you have experienced _____

List all medications and dosages _____

_____

Do you drive? ☐Yes ☐No If yes, do you have visual difficulty when driving? ☐Yes ☐ No

Do you wear glasses? ☐Yes ☐No Type of glasses: ☐Distance Rx ☐Readers ☐Bifocals ☐Progressives ☐Store – Bought Readers

Your Primary Care Physician: _____ Other Physician (specialist, etc.): _____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐Yes, I would rather discuss my Social History information (the following questions) directly with my doctor (check box)

Are pregnant or nursing? ☐ Yes ☐No

Do you use tobacco products? ☐ Yes ☐No Type: _____ How often: _____ How long _____(Years)

Do you drink alcohol? ☐ Yes ☐No Type: _____ How often: _____ How long _____(Years)

Family History (living or deceased)

Disease/Condition	Father	Mother	Brother	Sister	Son	Daughter
Cancer_____(Type)	☐	☐	☐	☐	☐	☐
Diabetes: Type 1 2	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Thyroid Disease: Hyper Hypo	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐

Review of Systems: Do you have any of the following? (Please list any **treatments** or **medication**(s) under condition.)

Eyes:
- Cataracts ☐
- Macular Degeneration ☐
- Glaucoma ☐
- Diabetes ☐
- Diabetic Retinopathy ☐
- Dry Eyes ☐
- Eye Infection, Inflammation ☐
- Eye Allergies ☐
- Floaters in Vision ☐
- Flashes of Light ☐
- Iritis or Uveitis ☐
- Retina Defect or Degeneration ☐
- Redness ☐
- Burning ☐
- Itching ☐
- Tearing ☐
- Discharge ☐
- Blurred Vision ☐
- Eyestrain ☐
- Eye pain ☐
- Light Sensitivity ☐
- Headaches ☐
- Poor Night Vison ☐
- Bothersome ☐
- Nighttime Glare ☐
- Double Vision ☐
- Total Loss of Vision ☐

_____
_____
_____
_____

Constitutional:
- Developmental Disability ☐
- Fatigue Syndrome ☐
- Cancer: _____(Type) ☐

Ear, Nose, Mouth and Throat:
- Hearing Impaired ☐
- Sinusitis ☐
- Dry Mouth ☐

Neurological:
- Headaches ☐
- Migraines ☐
- MS ☐
- Seizures ☐

Cardiovascular:
- High Blood Pressure ☐
- Stroke ☐
- Heart Disease ☐
- Elevated Cholesterol ☐

Respiratory:
- Asthma ☐
- COPD ☐
- Emphysema ☐

Gastrointestinal:
- Chron's Disease ☐
- Ulcerative Colitis ☐

Genitourinary
- Kidney Disease/Disorder ☐
- Prostate Disease ☐

Musculoskeletal:
- Rheumatoid Arthritis ☐
- Osteoarthritis ☐
- Fibromyalgia ☐

Integumentary: (Skin)
- Eczema ☐
- Rosacea ☐
- Psoriasis ☐

Endocrine:
- Diabetes Type 1 ☐
- Diabetes Type 2 ☐
- Thyroid Disease/Disorder ☐

Hematologic/Lymphatic: (Blood Disorder)
- Anemia ☐

Immunologic/Allergy:
- Lupus ☐

Psychiatric:
- Depression ☐

List any conditions and medications not listed above: _____

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The Most Advanced Ocular Disease Screening Technology is available at The Eye Studio

DILATION - We highly recommend a dilated eye exam to assess your risk for eye conditions such as glaucoma, macular degeneration, cataracts, diabetes, and other disorders. If you refuse dilation, there is a much greater chance that an eye disease could remain undetected and cause vision loss. Dilating drops have a few side effects, which include blurry vision and increased sensitivity to sunlight, that can last up to 4-6 hours.
There is no additional cost for dilation if performed at today's visit. If you choose to reschedule dilation to another day, you will be charged $35.

_____ Yes, I agree to have my eyes dilated _____ No, I do NOT want my eyes dilated

OCULAR COHERENCE TOMOGRAPHY (OCT) SCREENING - Using this state-of-the-art technology, we take a digital photograph and a 3-dimensional cross-sectional scan of the tissue in the back of the eye. This technology allows us to detect underlying eye disease (glaucoma, macular degeneration, diabetes, optic nerve disease) that may not be visible during a normal eye examination. OCT is an advanced health check that is highly recommended for patients 18 years and older and for patients with a personal or family history of diabetes, hypertension, glaucoma and macular degeneration.

_____ Please initial here if you would like to have the OCT done for a fee of **$39**.

VISUAL FIELD SCREENING – We utilize a virtual visual field analyzer that tests for loss of vision in your central and peripheral vision. This test can help diagnose and manage glaucoma, diabetes, stroke, optic nerve disease, retinal detachment, macular degeneration, and some brain tumors. We recommend this test for all patients who are experiencing headaches or any other visual disturbances. The screening test is not covered by insurance.

_____ Please initial here if you would like to have the visual field screening for a fee of **$39**.

DIABETIC EXAM & RETINAL SCREENING – For patients being managed for diabetes/pre-diabetes or on GLP-1 medications, our office requires retinal imaging as part of the exam to evaluate for diabetic retinopathy, diabetic macular edema, and optic nerve complications. Additionally, we send your primary care physician a detailed report of the exam findings. Most vision plans do not cover this evaluation. This may be billed to in-network medical plans and is subject to deductibles and copays per your insurance plan.

_____ The fee for the retinal imaging and medical documentation is $**79**.

NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, AND RESPONSIBILITIES

SERVICES PROVIDED WITHOUT REFERRAL AUTHORIZATION

As a member of a vision care program, I acknowledge for today's visit that I will assume full financial responsibility for services rendered to me if my vision insurance carrier denies or does not cover my claim for these services.

MEDICAL NECESSITY

If my insurance determines that a medical service and/or material are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material stated below.

COPAYs

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by the provider of service for Dr. Mona Patel OD, LLC (The Eye Studio).

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Dr. Mona Patel OD, LLC (The Eye Studio).

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Dr. Mona Patel OD, LLC (The Eye Studio) or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.

Our Patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.

HIPAA

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), of which I can request a copy, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operation such as quality assessments and physician certifications.

PATIENT/GUARDIAN ACKNOWLEDGMENT AND AGREEMENT

Patient Name (Print) _____

Patient Signature_____

*** If patient is a minor: I attest that I am the legal guardian with legal authority to make medical decisions for this minor**

Name of Legal Guardian _____

Guardian Signature_____ Date_____

Witness_____