DIAMOND VISION OPTOMETRY, INC.

Today's Date :_____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name :_____Birthdate :_____/_____/_____ Age :_____
Last First M.I

Occupation : _____Guardian (if applicable)_____

Address :_____City :_____State :_____Zip :_____

Cell #_____Work #_____Home #_____

Email :_____Preferred form of contact : ☐ cell ☐ text ☐ email ☐ work ☐ home

Emergency Contact :_____Relationship :_____Phone :_____

Last Eye Exam :_____Last Medical Exam :_____

Name of Medical Doctor :_____Phone :_____

Medical Insurance :_____ID or SS#_____

Primary Subscriber :_____Birthdate :_____Relationship to Patient :_____

Vision Insurance :_____ID or SS#_____

Primary Subscriber :_____Birthdate :_____Relationship to Patient :_____

PATIENT OCULAR / MEDICAL HISTORY

Do you have any allergies to medications? Yes___ No___ If yes, please list :_____

List medications you are taking :_____

List all major injuries, surgeries, hospitalizations :_____

Are you pregnant and/or nursing ? Yes___ No___

Do you wear glasses ? Yes___ No___ If yes, what do you like about your glasses?_____

Type of glasses : Distance___ Reading___ Progressives___ Bifocals___ How old are your current pair ?_____

Do you wear contact lenses ? Yes___ No___ If yes, how old are your current pair of lenses?_____

Type of contact lenses :_____What do you like about your contact lenses?_____

Please check any conditions that you have / or had in the past :

☐ Blurred vision	☐ Macular Degeneration	☐ Diabetes	☐ Arthritis
☐ Loss of vision	☐ Glaucoma	☐ High Blood Pressure	☐ Lupus
☐ Double vision	☐ Pain	☐ High Cholesterol	☐ Cancer
☐ Crossed / Lazy eyes	☐ Excess Tearing	☐ Heart Disease	☐ Asthma
☐ Flashes / Floaters	☐ Dryness	☐ Headache	☐ Lung Disease
☐ Eye Surgery	☐ Itching / Burning	☐ Migraine	☐ Other_____
☐ Cataract	☐ Eye Infection / Redness	☐ Stroke	_____
☐ Retinal Detachment	☐ Eye Injuries	☐ Thyroid Disease	_____

SOCIAL HISTORY

This, and all other information, is kept strictly confidential. However, you may prefer to discuss this portion directly with the doctor.

Do you drive ? Yes___ No___ If you have difficulty driving, describe :_____

Do you use tobacco products ? Yes___ No___ If yes, type / amount / how long :_____

Do you drink alcohol ? Yes___ No___ If yes, type / amount / how long :_____

Do you use recreational drugs ? Yes___ No___ If yes, type / amount / how long :_____

Have you ever been exposed to or infected with Gonorrhea___ Hepatitis___ HIV___ Syphilis___

Additional concerns:_____

FAMILY HEALTH HISTORY

Please check any conditions that apply to your immediate family members:

- ☐ Blindness
- ☐ Macular Degeneration
- ☐ Crossed / Lazy Eyes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retina Detachment
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Diseases
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Thyroid Disease
- ☐ Other_____

How did you hear about us?

- ☐ YELP!
- ☐ Diamond Vision Optometry Website
- ☐ Referral : Whom should we thank ? _____
- ☐ Insurance carrier Website _____

DILATION CONSENT

Dilated Fundus examination is performed by Optometrists and Ophthalmologists as a routine part of an eye examination. It is a diagnostic procedure that employs the use of mydriatic eye drops to enlarge the pupil in order to obtain a better view of the fundus of the eye. Dilation has been found to be a more effective method for evaluation of internal ocular health, observing the retina more completely to rule out maladies such as glaucoma, retinal detachment, cataracts, eye tumors, and other sight or life threatening conditions. These eye drops require about twenty minutes' time to fully dilate the pupil.

We always prefer to have our patients driven after the dilation, as the eye drops may cause blurred vision and light sensitivity for up to six hours.

Please note, you will be made aware if your insurance plan does not cover this procedure.

Please check one:

- ☐ YES, I give pemission to the Doctor to perform dilation today
- ☐ NO, I choose not to have dilation done. I understand that an exam of the retina through a dilated pupil is necessary to detect conditions that would otherwise be unobservable. These conditions, if undetected, may lead to partial or total vision loss.
- ☐ I prefer to schedule dilation to be done in the near future.

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I authorize the Optometrist to release any information including the diagnosis and records of any treatment or examination rendered to me or my dependent during the period of such eye care to third parties payers and /or health care practioners.

I authorize my insurance company to pay directly to **Diamond Vision Optometry, Inc.**

I understand that my insurance carrier may not cover some sevices and products, and benefit information does not constitute guarantee of payment. Deductible and fees not paid by my insurance carrier will be my sole reponsibility. I also understand that there is **NO REFUND** for rendered professional medical services related to eye exams or contact lens fitting or evaluations.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Patient's /Legal Guardian's Signature Date

_____ _____

Doctor's Signature Date

DIAMOND VISION OPTOMETRY
CONSENT FOR RELEASE OF
PROTECTED HEALTH INFORMATION

I, _____,

CONSENT TO THE RELEASE OF PROTECTED HEALTH INFORMATION THAT IS REQUIRED TO CARRY OUT TREATMENT AND PAYMENT OF HEALTHCARE OPERATIONS ON MY BEHALF.

I HAVE READ THE NOTICE OF PRIVACY PRACTICES AND AM AWARE OF THE FOLLOWING:

- I HAVE THE RIGHT TO PLACE RESTRICTIONS ON THE WAY MY PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED.
- I UNDERSTAND THAT *DIAMOND VISION OPTOMETRY* IS NOT REQUIRED TO AGREE WITH MY REQUESTED RESTRICTIONS. I ALSO UNDERSTAND THAT ONCE *DIAMOND VISION OPTOMETRY* AGREES TO MY RESTRICTIONS, IT MUST COMPLY WITH THOSE RESTRICTIONS.
- I HAVE THE RIGHT TO REVOKE MY CONSENT FOR THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AT ANY TIME. I UNDERSTAND THAT IF I CHOOSE TO REVOKE MY CONSENT, I MUST SUBMIT A WRITTEN STATEMENT THAT IS SIGNED BY ME.
- I UNDERSTAND THAT *DIAMOND VISION OPTOMETRY* MUST IMMEDIATELY COMPLY WITH MY REQUEST TO REVOKE CONSENT, EXCEPT TO THE EXTENT THAT HAS ALREADY TAKEN SOME ACTION THAT WAS BASED ON MY ORIGINAL CONSENT.
- *DIAMOND VISION OPTOMETRY* RESERVES THE RIGHT TO CHANGE FROM TIME TO TIME THEIR PRIVACY PRACTICES THAT ARE DESCRIBED IN THIS ATTACHED NOTICE. WHENEVER *DIAMOND VISION OPTOMETRY* CHANGES THEIR PRACTICES, THEY WILL MODIFY THE NOTICE ACCORDINGLY AND THEY WILL INFORM ME BEFORE I AM TREATED AT THIS OFFICE.

INDIVIDUAL:	WITNESS:
_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
SIGNATURE	SIGNATURE
_____	_____
DATE	DATE