THE OPTOMETRIC GROUP

# Patient Registration Form

Name: _____ Date: _____

Email: _____ Birth Date: _____

Address/City/Zip: _____

Phone Number: _____ ☐ Cell ☐ Home ☐ Work Ethnicity: _____

Occupation: _____ Hobbies: _____

## Vision Insurance

Plan Name:
Member ID#:
Date of Last Exam:
Primary Insured:
Relationship to Insured (check one):
☐ Self ☐ Spouse ☐ Dependant

## Medical Insurance

Plan Name:
Member ID#:
Primary Insured:
Relationship to Insured (check one):
☐ Self ☐ Spouse ☐ Dependant
Date of Last Physical Exam:
Primary Doctor's Name:

## What is the reason for your appointment today? *Describe any eye problems or concerns you are having.*

_____

## Your Eye/Medical History

*Please check yes/no as applies to your self.*

| | Yes | No |
|---|---|---|
| Blurry Vision | | |
| Eye Injury | | |
| Eye Pain | | |
| Eye Discharge | | |
| Red Eye | | |
| Eye Infection | | |
| Dry Eye | | |
| Eye Allergies | | |
| Strabismus (Eye Turn) | | |
| Amblyopia ("Lazy Eye") | | |
| Loss of Vision/Blindness | | |
| Glaucoma | | |
| Cataracts | | |
| Retinal Disease | | |
| Experiencing flashes of lights | | |
| Floaters | | |
| Light Sensitivity | | |
| Double Vision | | |
| Have you had eye surgery? | | |
| Are you interested in LASIK? | | |
| Do you wear glasses? | | |

How old are your glasses?

_____

| | Yes | No |
|---|---|---|
| Developmental Disability | | |
| Cancer | | |
| Hearing Loss | | |
| Sinusitis | | |
| Mental/Emotional Problems | | |
| High blood pressure/Hypertension | | |
| Stroke | | |
| Heart Disease | | |
| Asthma | | |
| Sleep Apnea | | |
| Gastrointestinal Problems | | |
| Kidney Disease | | |
| Sexually Transmitted Disease | | |
| Arthritis | | |
| Ankylosing Spondylitis | | |
| Eczema | | |
| Rosacea | | |
| Psoriasis | | |
| Cold Sores/Shingles | | |
| Diabetes | | |
| Thyroid Dysfunction | | |
| High Cholesterol | | |
| Autoimmune Disease | | |

| | Yes | No |
|---|---|---|
| Do you drink alcohol? | | |
| Do you smoke cigarettes? | | |
| *if yes, do you smoke every day?* | | |
| *if no, did you use to smoke?* | | |
| Do you use recreational drugs? | | |
| Are you pregnant or nursing? | | |

### Contact Lens Wearers

Current brand:_____
How old are your current lenses? _____
Are you happy with your contacts? _____
How many hours do you wear them in a day?
_____

### List Allergies:

_____
_____

### List Medications *(include over-the-counter, supplements, etc.):*

_____
_____
_____
_____
_____

## Family Eye/Medical History

*Please check yes/no as applies to your blood relatives (mother, father, siblings, grandparents, aunts and uncles).*

| | Yes | No |
|---|---|---|
| Cancer | | |
| High Blood Pressure | | |
| Diabetes | | |
| Cataracts | | |
| Macular Degeneration | | |
| Glaucoma | | |
| Crossed Eyes | | |

**Office use only** – Do not write in this box.

_____
_____
_____
_____

Medical History Reviewed with patient ☐ by: _____(doctor sign)

☐ New Sphere/Toric/Multifocal
☐ Re-fit Sphere/Toric/Multifocal
☐ Schedule CL Follow-up
☐ Schedule DFE
☐ Prob-Spec Follow-up: _____
☐ Print SRx/CLRx/Med Rx
☐ A/R
☐ Poly
☐ PALs
☐ Other: _____

## Financial Policy (V.2.9.2015)

Welcome to our clinic and thank you for trusting your eye care needs to our office. So that we may better serve all our patients, the following details our Financial Policy effective 5/12/2014.

**Exam Fee Payment**
Full payment is due at time of service. We accept cash, checks, and major credit cards (VISA, Master Card, Discover, American Express). If you are using insurance benefits for your exam today, our staff will help you understand your insurance benefits and let you know what co-pays are due, if any. If you are undergoing a Contact Lens Evaluation and have an allowance toward a contact lens exam and materials, you may elect to use some of that allowance toward the Contact Lens Evaluation Fee. Since your contact lens evaluation may take multiple visits, the fee may be assessed upon finalizing the contact lens prescription and we will bill your insurance at that time along with any contact lens materials you purchase.

**Insurance**
There are many different types of insurance payors. Most of the time, your Vision Plan (VSP, EyeMed, MES, etc.) is used for your comprehensive eye exam. Depending on your situation however, it may be appropriate to bill your medical insurance (Aetna, Blue Cross/Blue Shield, Medicare, etc) for medical eye issues such as red eyes, emergency visits, and the like. Please present both types of insurance identification cards to our staff so that we may better direct your eye care. We will do our best to explain our recommendations to you. Some or all services and materials provided to you may not be covered as "reasonable and necessary" under the medical insurances. The balance may be your responsibility whether or not the insurance company pays.

**Eyewear and Contact Lens Purchases**
Full payment is due at the time of order for all eyewear and contact lenses.

**Nonrefundable Materials**
All prescription optical materials are customized and fabricated specifically for each individual patient. Fees for these materials are non-refundable, and once ordered, become the financial responsibility of the patient. We are not responsible for any materials not picked up after 90 days from delivery to our office.

**Special Orders**
With regard to requests for frames not in stock, we will try to accommodate special orders, if possible. Special orders must be paid for in full prior to order placement and will be subject to an additional non-refundable $25 shipping and handling fee. Cancellation or returns made after order has been placed (but before dispensing) will be charged a 50% restocking fee. Once dispensed, there will be no returns accepted.

**Initial here** (financial policy receipt): _____

## Contact Lens Agreement (V.2.9.2015)

Contact lenses are a great vision enhancing treatment option for patients of many different needs. Thank you for letting us participate in your contact lens evaluation and care here at Trung V. Tran, OD Optometric Corporation (3824 La Sierra Avenue, Riverside, CA 92505).

**The Contact Lens Evaluation is an additional service apart from the Comprehensive Examination**. Any patient wishing to be fit in contact lenses must undergo a Comprehensive Exam first. If the doctor decides that you are a good candidate for contact lenses, the Contact Lens Evaluation can proceed the same day and/or on subsequent visits.

Contact lenses are medical devices placed in the eye and therefore require special attention. The evaluation involves the doctor determining your unique lens power and size requirements. The evaluation also ensures that the recommended contact lenses are comfortable and safe to use so that complications such as infections can be avoided. The evaluation may include one or more follow-ups to see if there are any issues that can arise with continued use of the lenses.

During the fitting process, you will receive lens insertion and removal training and trial lenses based on the doctor's recommendations. Trial lenses are not for permanent use and are meant to be used for the trial period until the doctor finalizes your Contact Lens Prescription. Trials will only be dispensed at contact lens follow-up visits and will not be dispensed at other times. Patients must undergo all recommended follow-ups prior to receiving the final Contact Lens Prescription. Only patients with a valid Contact Lens Prescription may purchase contacts for use. Receiving a trial lens is not the same as receiving a contact lens prescription.

**Contact Lens Evaluation Fees**:
Your Contact Lens Evaluation fee is based on the complexity of the contact lens fit. The evaluation fees range from $45-100 based on your visual and eye health needs. These fees are due on the date of service. The Contact Lens Evaluation Fee covers follow-up care for three follow-up visits within 60 days after the initial contact lens fitting date. Any additional contact lens follow-up beyond the third visit or the first 60 days will have a $25 fee. We urge that you follow all instructions in the care of your vision and that you keep all scheduled appointments to maintain your eye health.
Once finalized, your contact lens prescription is valid for one year. Once expired, contact lens prescriptions will not be renewed without an annual exam to determine if changes have occurred.

Return Policy:

- The Contact Lens Evaluation Fee is non-refundable
- Unopened AND unexpired AND unmarked boxes of contact lenses can be returned for credit that can be used for other eyewear or contact lens purchases for you and/or your friends and family.

Your Eye Health is Our Priority:

- Use and clean your lenses only as instructed and prescribed. Do no over wear your lenses or attempt to make them last longer than intended.
- If you have red, painful or itchy eyes or if there is discharge coming from your eyes, remove your lenses and call our office immediately to make an appointment. Any changes to your vision and anything out of the ordinary should also be reported to us.

**Contact Lens Patients Sign Agreement**: _____

## Notice of Privacy Practices, Pursuant to HIPAA Rule of 1996 (V.2.9.2015)

Your privacy is important to us. As such, this notice serves as documentation on how we protect your privacy and disclose certain information, when required by law. You have the right: to get a copy of your medical record, to correct your paper or electronic medical record, to request confidential communication, to ask us to limit the information we share, to get a copy of this privacy notice, to choose someone to act for you, to file a complaint if you believe your privacy rights have been violated. Since your medical information is confidential, we keep your information guarded. However, we are allowed or required to share your information in order to comply with the law and other healthcare regulations. We may use and share your information to: treat you, run our organization, bill for your services, help with public health and safety issues, do research, comply with the law, respond to organ and tissue donation requests, work with a medical examiner or funeral director, address workers' compensation/law enforcement/other governmental requests, respond to lawsuits and legal actions. Please be aware that we are required to maintain the privacy and security of your protected health information. We will not use or share your information other than as described here unless you tell us we can in writing. Please inform the staf if you would like to receive a more detailed copy of this Notice of Privacy Practices.

I authorize Trung V. Tran, OD Optometric Corporation, DBA "The Optometric Group" to use my name on claims that relate to health insurance benefits and eye care services provided. I authorize payment of health/vision benefits to "The Optometric Group" as a result of services provided. I understand that I am financially responsible, whether my insurance pays or not, for any charges incurred by me. I confirm receipt of the Notice of Privacy Practices.

**Signature on File**: _____ **Date**: _____