Grand Lake Optometry
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Your name:______________________________________ Date:___________________________
Employer:__________________ Occupation:______________

Personal medical information

Primary care physician:_____________________________ Date of last physical: _______________

Check the box if you have a history of **or** take medications for any of these systems:

Diabetes Type____ Year diagnosed______	Hypertension	High cholesterol	Cancer
Respiratory (asthma, COPD)	Kidney/urinary disorder	Bleeding disorder	Stroke
Autoimmune disorders	Ear/Nose/Throat	Skin disorder	HIV or AIDS
Neurologic (seizure/sleep disorders)	Muscles/Bones/Joints	Heart disease	Thyroid disorder
Syphilis/TB/Infection	Depression/anxiety	Allergies/hay fever	Blood/Lymph
Stomach/intestinal disorder			

Please explain any of the above:____

List any other medical conditions that you have:____

Surgeries (type and date):____

List any medications that you currently take, including over the counter products, aspirin, and birth control: None

____

List any drug allergies that you have: None ____

Women: Are you currently pregnant or nursing? Y N

What is your weekly alcohol consumption? None Between 1-4 drinks Between 5-8 drinks More than 8 drinks

Do you smoke? ? Y N

Do you have a history of smoking? Y N If yes, for how long? __________ How many packs per day?_____

Family history (M=mother, F=father, S=sister, B=brother, GM=grandmother, GF=grandfather, C=child)

Check the box if a family member has any of the following conditions and please indicate who has the condition:

Diabetes	Hypertension	High cholesterol	Heart disease	Migraines
Glaucoma	Macular degeneration	Retinal problems	Lazy eye	Blindness

Personal eye information

Do you have any particular eye concerns? ____

Are you interested in:

New eyeglasses	Contact lenses	Refractive surgery (Lasik)	Prescription sunglasses	Non-prescription sunglasses	Computer eyewear

Check the box if you have or have had any of the following:

Eye surgery   Eye injury   An eye condition (please describe, i.e.: glaucoma, macular degeneration)
____

When was your last eye examination? ______________________

List any eye drops that you currently use, including over-the-counter products:_____________________________

Do you wear eyeglasses? Y N   If yes, how old are they? ___________________________________

Do you wear contact lenses? Y N   If yes, what type of lenses are they? Soft contacts Rigid contacts

Patient signature: _________________________________ Date: ______________________

Doctor's signature: _________________________________ Date: ______________________

(For doctor use) Review, initial and date upon patient's return: __________ __________ __________

SPECTACLE PRESCRIPTION WARRANTY

New lenses and frames received from our office are warranted against manufacturers' defects for one year from the date that they are received. Some restrictions apply (i.e. sale frames, economy packages, Oakley frames that are filled with non-Oakley lenses). Putting new lenses into frames that you choose to reuse or have been purchased elsewhere is done at your own risk; our office will not be responsible for any damage or breakage that may occur during or after the lens fabrication process. If you choose to purchase a frame from our office and take it elsewhere for lenses, the warranty becomes void. Once you receive your new eyeglasses, you have a 30 day period to report any issues with the lenses or the prescription. Any remakes beyond that period may result in new lens fees at our discretion.

CONTACT LENS EVALUATION/PRESCRIPTIONS

In order to acquire or maintain a valid contact lens prescription and order contact lenses, you must receive a contact lens evaluation and/or fitting/refitting yearly. If you have vision insurance that covers your general eye examination, the fee for contact lens services is not covered by that benefit. You will need to check your coverage carefully to determine if you have benefits to cover these expenses or what your out-of-pocket costs will be. Any refitting (change to your current contact lens fit) that is recommended by the doctor will incur additional fees over and above your annual contact lens evaluation fee, so if you wish to know exactly what your out-of-pocket costs will be, please ask before proceeding. We are happy to answer any questions and explain your benefits to you as best we can, but you are ultimately responsible for understanding what your benefits are. A contact lens prescription is not finalized, and lenses cannot be ordered, until you have completed the appropriate follow-up visits determined by the doctor.

PAYMENT AND CANCELLATION POLICY

Payment for materials and services are due when services are rendered. We request payment in full before ordering any materials (i.e. contact lenses, frames, eyeglasses), and cancelled orders will be assessed a restocking fee once the order has been processed. Refunds for cancelled orders and returned items are given in the form of store credit. Please choose your materials carefully.

ADVANCE BENEFICIARY NOTICE

I authorize Grand Lake Optometry to act as my agent in obtaining payment of my insurance benefits from ______________________ /______________________. I authorize payment of these benefits directly to Grand Lake Optometry on my behalf for services and materials rendered. I understand that I am financially responsible for all charges regardless of insurance status as well as any associated cost for collection should such action become necessary. Grand Lake Optometry agrees to answer questions and provide information about my benefits to the best of their ability, but I understand that due to the countless plans that exist and the complexity of each plan, it is ultimately my responsibility to make certain that I understand what my benefits are. I hereby authorize Grand Lake Optometry to release any information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

***By signing this form I acknowledge that I have read and agree to the policies stated above*.**

Signature:____ Date:__________________________

EXCHANGE OF HIPAA PROTECTED INFORMATION

Text messaging and email are not secure and could potentially be viewed by third parties. I consent to having Grand Lake Optometry communicate with me via text and email with regards to my HIPAA protected information such as eyeglass and contact lens prescriptions, examination results, treatment recommendations, billing issues, etc.

Signature:____ Date:____________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been given the opportunity to review Grand Lake Optometry's Notice of Privacy Practices and/or have received a copy if requested.

Signature:____ Date:__________________________