Thank you for choosing ONE HOUR OPTICAL for your eye care needs!

☐ **Mr. /** ☐ **Mrs. /** ☐ **Ms. /** ☐ **Dr.** **Today's Date** _____

Name: Last _____ **First** _____ **MI** _____ **Preferred Name** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone # _____ **Work Phone #** _____ **Cell Phone #** _____

Preferred Phone Number: ☐ Home / ☐ Work / ☐ Cell

Email Address _____

Birth Date _____ **Age** _____ **Social Security #** _____ **Occupation** _____

Marital Status: ☐ Married / ☐ Single / ☐ Divorced / ☐ Widowed **Preferred Language** _____

Race: ☐ African Am / ☐ Asian / ☐ Native Indian ☐ Pacific Islander / ☐ White / ☐ Other **Ethnicity:** ☐ Hispanic / ☐ Not Hispanic

Have you been to One Hour Optical before? ☐ Yes / ☐ No **How did you select us?** _____

Do you have vision insurance? ☐ Yes / ☐ No

If yes: ☐ VSP / ☐ Spectera / ☐ Davis / ☐ Avesis / ☐ Eyemed / ☐ Medicaid / ☐ Medicare / ☐ Other _____

Subscriber Name _____ Member ID # _____ Member Date of Birth _____

Do you have health insurance? ☐ Yes / ☐ No If yes, who is it through? _____

Subscriber Name _____ Member ID # _____ Member Date of Birth _____

Insurance: I authorize the exchange of information necessary for treatment, payment and healthcare operations, including the processing of insurance claims. I understand that I may have co-payments, deductibles and overage costs and ultimately I am responsible for all fees incurred. One Hour Optical does not guarantee the accuracy of benefit information given to us from insurance companies. If you have questions about your coverage, please contact your insurance representative.

Patient Signature **X** _____ Date _____

HIPAA Notice: I acknowledge that I have received a copy of or understand One Hour Optical's Notice of Privacy Practices (available from our front desk).

Patient Signature **X** _____ Date _____

Notice to Contact Lens Patients: The contact lens fitting/evaluation fee provides you with the diagnostic contact lenses needed for your contact lens prescription to be finalized. Follow-up appointments related to your contact lenses are included in this fee for up to three months, in most cases. Professional service fees, including the examination charges and contact lens fitting fee, are non-refundable. Federal law mandates that contact lens prescriptions expire one year from the date of the fitting.

Please initial that you have read and understand: _____

Are you allergic to any medications? ☐Yes / ☐No If yes, which medications? _____

Do you take any medications? ☐Yes / ☐No If yes, please list all (including over-the counter and eye drops)

_____

_____

Do YOU have any of the following eye conditions?

☐Blurry Vision	☐Eye Pain	☐Double Vision	☐Dry Eyes
☐Eye Itching	☐Lazy Eye	☐Prior Eye Surgery	☐Eye Burning
☐Flashes / Floaters	☐Discharge	☐Eye Redness	

Do YOU have any of the following medical conditions?

☐Seasonal Allergies	☐Hormone Dysfunction		
☐Rheumatoid Arthritis	☐Glaucoma	☐Fibromyalgia	
☐Lupus	☐Cataracts	☐Muscular Dystrophy	☐Heart Disease
☐Crohn's Disease	☐Macular Degeneration	☐Osteoarthritis	☐High Blood Pressure
☐Colitis	☐Multiple Sclerosis	☐Develop. Disability	☐Stroke
☐Stomach Ulcers	☐Epilepsy	☐Extreme Weight Loss	☐High Cholesterol
☐Depression	☐Alzheimer's	☐Fever	☐STDs
☐Panic Disorder	☐Parkinson's	☐Trauma	☐Asthma
☐Schizophrenia	☐Eczema	☐Anemia	☐Emphysema
☐Diabetes	☐Rosacea	☐Leukemia	
☐Thyroid Dysfunction	☐Psoriasis		

Does anyone in your FAMILY have any of the following conditions?

☐Glaucoma	☐Macular Degeneration	☐Cataracts
☐Other Eye Problems	☐High Blood Pressure	☐Diabetes

Social History: This information is confidential. However, you may discuss this directly with the doctor, if you prefer.
Do you use tobacco products? ☐Yes / ☐No If yes, what type? Amount? How long? _____
Do you drink alcohol? ☐Yes / ☐No Do you use illegal drugs? ☐Yes / ☐No
Have you been infected with HIV, Gonorrhea, or Hepatitis? ☐Yes / ☐No

When was your last eye exam? _____ **What office?** _____ **Were you dilated?** ☐Yes / ☐No

Do you wear contact lenses? ☐Yes /☐No **What kind?** _____ **Do you want a contact exam today?** ☐Yes /☐No

Are you currently pregnant or nursing? ☐Pregnant / ☐Nursing / ☐No **Are you interested in LASIK?** ☐Yes / ☐No

Pupil Dilation Consent: In order to fully determine the health of the eyes, pupil dilation may be necessary. Some eye diseases are found in the periphery of the eye and pupil dilation makes it easier to see the periphery. If the doctor decides to dilate, eye drops are used to enlarge the pupils. This may cause sensitivity to light and blurry near vision for 4-6 hours. People usually do not have problems driving after pupil dilation.

Please initial: I Accept Pupil Dilation, if necessary _____ OR I Refuse Pupil Dilation_____