look + see
VISION CARE

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name		Preferred name or nickname (if applicable)	
Street Address		City	State / Zip
Home Ph#	Cell#	Birth Date	Parent/Guardian (if applicable)
Occupation	Employer		Work#
Email		How did you hear about us?	

PATIENT MEDICAL HISTORY

Do you or a family member have problems with any of the following (please check all that apply):

	SELF	FAMILY	SPECIFY		SELF	FAMILY	SPECIFY
Blindness	☐	☐		Cardiovascular Dz	☐	☐	
Cataracts	☐	☐		Diabetes	☐	☐	
Macular Degeneration	☐	☐		Cancer	☐	☐	
Glaucoma	☐	☐		High Blood Pressure	☐	☐	
Retinal Detachment	☐	☐		Headaches	☐	☐	

List other Eye Conditions: _____

List other Medical Conditions: _____

Current Medications: _____

List medication allergies: _____

Reason for today's visit _____ Date of last eye exam _____ Dilated? ☐ Y / ☐ N

Check any that apply: ☐ Dry Eyes ☐ Blurred Vision ☐ Eye Strain ☐ Lazy Eye ☐ Flashes/Floaters ☐ Itchiness

List any other problems: _____

Any eye surgery or trauma? ☐ Y / ☐ N Type _____ ☐ Right ☐ Left Date _____

Do you wear glasses? ☐ Y / ☐ N Do you wear contacts? ☐ Y / ☐ N CL Brand _____

OCULAR HEALTH EVALUATION

We believe checking your eye health is just as important as your vision! As there are no pain receptors in the back of the eye, most ocular and systemic issues such as glaucoma, macular degeneration, diabetes, and high blood pressure have no symptoms aside from vision loss.

Our doctors request that **ALL** new patients have the **Optomap Retinal Imaging** procedure performed at the initial visit in order to establish a baseline to track your eye health over time. This advanced technology allows us to scan your retina WITHOUT the side effects of dilation.

Medical and vision insurances do not cover this service. There is a **$39 fee** for this procedure.

☐ **I ELECT** to have the Optomap Retinal Imaging and understand it will provide a permanent baseline comparison for future visits. I understand that based on the doctor's assessment of the scan and examination that dilation may also be recommended. I am aware that this procedure is an additional $39 fee.

☐ **I DECLINE** the Optomap Retinal Scan and choose to be dilated today. I understand that dilation will take an additional 30-45 minutes and that my eyes will be more light sensitive and my vision will be blurry (mostly on the computer and while reading) for about 3-4 hours. I am aware that this procedure is included with my routine examination.

If you choose not to be dilated or to receive the Optomap Retinal Imaging, you agree not to hold Look + See Vision Care liable for any delay in diagnosis or treatment that may occur.

Signature: _____ **Date** _____ *(Continue on reverse side)*

OFFICE USE:	DOS	CPT	ICD

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PRACTICE POLICIES

NOTICE OF PRIVACY PRACTICES

This form is posted in the office and we will gladly provide you with a copy of this notice if you would like to keep one for your personal records. This notice describes how your personal health record information may be used or disclosed and how you may gain access to this information. Examples of uses of your health record information include patient recall, prescription verification or request, and for co-management with another health professional. Signing below indicates that you have been made aware of our privacy practices.

FINANCIAL ARRANGEMENTS

KNOWING YOUR INSURANCE:

- Please be advised that if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Look + See Vision Care. All co-pays and non-covered services are due at the time of the appointment. All benefits quoted are not a guarantee of payment by your insurance company and final determination can only be made when the claim is processed. If your insurance company has not reimbursed our office in full within 90 days, you will be responsible for payment of any remaining fees owed.

GLASSES RECHECK AND REMAKE POLICY:

- We offer prescription rechecks one time at no cost within 90 days of the date on which the prescription was determined. After 90 days, a fee will be incurred. Rechecks will not be performed after 6 months from the original exam date and a new exam will be required.

- As our commitment to you, we will adjust your glasses purchased from us at no charge for as long as you own them. Most frames are covered under warranty for manufacturing defects for one year.
  Your glasses are a custom product, in which the lenses are designed by a lab specifically for your prescription and frame of choice. Therefore, they cannot be reused and no refunds will be given. If you are unhappy with your glasses for any reason, please bring them back to us so we may change them to meet your expectations. We offer a one time remake at no charge within 90 days from service date.

CONTACT LENS EVALUATION POLICY:

- Contact Lens evaluations must be performed within 60 days of the routine health evaluation. A new full exam is required after the 60 day period. All contact lens evaluations include unlimited follow ups for 60 days. Any issues with the contact lenses must be brought to our attention within the 60 days. Following 60 days, an office visit charge will be incurred.

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. If you have any questions about this form, please do not hesitate to ask.

Signature: _____ **Date** _____