Welcome

Optical Infinity, 860 Hebron Pkwy. #103 Lewisville, TX 75057

Please take a moment to complete the following information.

Patient Information:

First Name _____ Last Name _____, Name that you preferred to be called _____

Gender: M, F, Marital Status: Single, Married, Other

Age_____, Date of Birth _____/_____/_____ SSN# _____-_____-_____, Driver License#_____

Street Address _____ Apt.#_____

City _____ State: _____ Zip code _____

Occupation _____ Patient's Employer ____ _____

Contact Info.

Best Phone Number_____, Email _____

Other Phone Number _____, Spouse's Phone _____

Spouse Info.

Spouse's Name _____ Date of Birth _____ Email _____

Guardian's Names:

Name _____ DOB_____, Relationship_____

Name _____ DOB_____, Relationship_____

Emergency contact: (specify someone who does not live in your household)

Name _____ Relationship _____

Home _____ Work _____ext_____, Cell _____

Vision Insurance information: (We do not file medical insurance)

Name of Insurance Company _____

Phone Number (for Provider) _____

Member ID _____, Group or account number _____

Primary Insured's Name _____, Primary's DOB _____,

Primary Insured's SS# _____

Primary Insured's Employer _____

Optical Infinity

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NOTICE OF HIPPA PRIVACY PRACTICE

I have read Optical Infinity's Notice of Privacy Policies.

Signature of responsible party _____ Date_____

OFFICE POLICIES

1. If you are late for your appointment by more than 15 minutes, we may ask you to reschedule.
2. We may call you to confirm your appointment. If your appointment is not confirmed, we may have to cancel it.
3. If you are unable to keep the time reserved for you, please contact us at 972-316-3937 within 24 BUSINESS HOURS to reschedule and avoid an appointment cancellation fee ($25).
4. Small children or toddlers will not be allowed in the exam room or waiting room unless restrained in a stroller or attended by another adult. Our office staff cannot be responsible for supervising them.
5. If we cannot verify your insurance at the time of your service, you will be charged as a private paying patient.

FOLLOW-UP APPOINTMENTS

For Contact lenses:

There is no charge for follow-up visits during the first 90 days following the initial exam date. After this time period, you will be charged again for a full contact lens fitting fee. And, if you have to set up a follow-up appointment after the 90 day period, the secondary fitting charge will include three follow-up visits within the two months of the secondary fit. If you have any issues with your contact lens after your original contact lens exam, we suggest you set up a follow up appointment as soon as possible and not wait too long to avoid the secondary fitting fee. The prescription will be written only for the amount of lenses to cover the rest of the year from the most recent comprehensive examination, and given an expiration date of 1 year from the most recent comprehensive eye examination and refraction.

For eyeglasses:

If you have any issues with your RX for your eyeglasses, please call us and set up a follow-up appointment as soon as possible. There is no charge for follow-up visits and remake of the lenses during the first 90 days. After this period, you will be charged $70 for a follow-up visit and will be charged for the remake of the lenses. After 6 months, you will be charged a regular exam fee.

I have read and accept the above office policy and follow-up appointments policy.

Signature of responsible party: _____ Date _____

Financial Agreement

In consideration for the services to be rendered to me, I hereby assume full responsibility to pay for those services in accordance with the rates now in effect at Optical Infinity to the extent that I am legally responsible for such payment. Payments that I am responsible for may include, but are not limited to, balance after insurance and non-covered services.

I hereby assign to Optical Infinity any and all benefits for services rendered under insurance policies, or reimbursement. I acknowledge any balance not covered or paid for such policies is my legal responsibility. I understand that if my account is turned over to a collection agency, a 30 % service charge will be added to the balance. I understand that I am required to inform Optical Infinity of any address, phone number, or insurance changes.

THIS IS A LEGAL FINANCIAL AGREEMENT OF BENEFITS FORM. BE SURE ANY QUESTIONS YOU MAY HAVE ARE ANSWERED BEFORE YOUSIGN AT THE BOTTOM OF THE PAGE.

Medical Records release and forms.

I understand that if I request a copy of medical records to be sent to another doctor, I must allow 7 days for processing form the time I submit a signed authorization. I understand that if I request my medical records to be released to me, I must pre-pay $25 for in house records or $30 for records in storage and allow 15 business days for processing from the time I submit a signed authorization.

I understand if I submit a disability form, Family Medical Leave Act form, or any other form that requires a doctor signature and /or specific information to be completed, I will be charged $15 and must allow 10 business days for processing.

Release of records to a designated third-party.

In addition to my treating physicians and medical facilities, I authorize Optical Infinity to release and discuss my medical/billing information and records to the following individuals.

1. Name _____ Relationship_____

Patient Signature : By signing below, I am verifying that I have read each of the section on this page. I understand each section and consent and agree with the information stated in each section.

_____ _____ _____

Legal Representative's Relationship to Patient **Date**

Health History: **Name_____**

What is the main reason for today's exam? Circle one. Annual exam, problem with eye(s)

I want to get…. new glasses, contact lenses, or both.

When was your last eye exam? _____

When was your last health exam? _____

Past Illness or Injuries: _____

Past Surgeries:

Surgeries	Date of Surgeries

Current Medication:

Name of Medication	For	Dosage

Current Eye Drops:

Name of Eye Drops	For	Dosage

Drug Allergies (please list if any) _____

Symptoms of Drug Allergies _____

Specific Allergies (mold, pollen, grass, etc.) _____

Eye History:

Glaucoma	Yes, No	Dryness	Yes, No	Strabismus(Crossed Eyes)	Yes, No
Cataract(s)	Yes, No	Excess Tearing	Yes, No	Blurred Vision Distance	Yes, No
Macular Degeneration	Yes, No	Eye Pain or soreness	Yes, No	Blurred Vision Near	Yes, No
Retinal Detachment	Yes, No	Foreign Body Sensation	Yes, No	Distorted Vision	Yes, No
Color Blindness	Yes, No	Infection of Eye or Lid	Yes, No	Double Vision	Yes, No
Headaches	Yes, No	Itching	Yes, No	Floaters or Spots	Yes, No
Glare/Light Sensitivity	Yes, No	Mucous Discharge	Yes, No	Fluctuating Vision	Yes, No
Tired Eyes	Yes, No	Drooping Eyelid	Yes, No	Loss of Vision	Yes, No
Amblyopia (Lazy Eye)	Yes, No	Redness	Yes, No	Loss of Side Vision	Yes, No
Burning	Yes, No	Sandy or Gritty Feeling	Yes, No		

General Health Condition:

Fever	Yes, No	Respiratory(Asthma)	Yes, No	Anxiety or Depression	Yes, No
Weight Loss	Yes, No	Gastrointestinal	Yes, No	Thyroid, Diabetes	Yes, No
Other Symptoms	Yes, No	Kidney	Yes, No	Blood/ Lymph	Yes, No
Ears, Nose, Throat	Yes, No	Muscles, Bones, Joints	Yes, No	Allergic	Yes, No
Cardiovascular (High Blood Pressure, etc.)	Yes, No	Skin	Yes, No	Are you pregnant?	Yes, No
		Neurological (Multiple Sclerosis)	Yes, No	Are you nursing?	Yes, No

Family History:

Eye Diseases		**Relationship to Patient**	**Systemic Diseases**		**Relationship to Patient**
Amblyopia (Lazy Eye)	Yes, No		High Blood Pressure	Yes, No	
Blindness	Yes, No		Kidney Disease	Yes, No	
Cataract(s)	Yes, No		Lupus	Yes, No	
Color Blindness	Yes, No		Stroke	Yes, No	
Glaucoma	Yes, No		Thyroid Disease	Yes, No	
Macular Degeneration	Yes, No		Cancer	Yes, No	
Retinal Detachment	Yes, No		Diabetes	Yes, No	
Strabismus (Eye Turn)	Yes, No		Other	Yes, No	

Social History:

Current Occupation: _____ Years _____ Employer_____

Spectacle Lens History:

Do you drive?	Yes, No
Do you have glare problems?	Yes, No
Do you have visual difficulty when driving?	Yes, No
Do you have problems with night vision?	Yes, No
Do you currently wear glasses?	Yes, No
Type of glasses:	Full Time, Part Time, Distance, Readers
Glasses Owned:	Single Vision, Bifocals, Trifocals, Backup, Safety, Progressive
Have you had trouble in the past with glasses?	Yes, No
Do you wear sunglasses?	Yes, No
Are they prescription sunglasses?	Yes, No
Do you currently wear contact lenses?	Yes, No
Type of contact lenses:	Single Vision, Mono Vision, Bifocals
Name of the Contact lenses (brand):	Biofinity, Proclear, Acuvue Oasys, AirOptixAqua, AirOptixN&D, other
Name of the Contact lens Solution:	Opti Free, Bio True, Complete, Renu, Clear Care, Menicare, Boston
How often do you replace the lenses?	2 weeks, 3 weeks, 4 weeks, 5 weeks, 6 weeks, 7weeks, 2 months

Social History

Do you engage in regular exercise?	Yes, No
Do you drink alcohol? If yes, how much/ often:	No, Occasional, 1-2 per day, 2-3 per day, 4+ per day
Do you smoke?	No, ½ pack/day, 1 pack/ day, +1 pack/day
Do you use Illegal Drugs?	Yes, No
Hobbies / Interests:	