

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

(Circle One:) Mr. Mrs. Ms. Dr. Name _____

Address _____ Last _____ First _____ MI _____ Preferred Name _____ Apt# _____ Preferred Phone # (____) _____

City _____ State _____ Zip Code _____ Alternate Phone # (____) _____

Birth Date ___/___/___ Age _____ Social Security # _____ Occupation/Grade _____

Individual responsible for patient's account _____ Relationship to Patient _____

Have you been to ONE HOUR OPTICAL Before? Y / N How did you select our office? _____

Name of Vision Insurance Company VSP / Spectera-OptumHealth/ Davis / Eyemed / UFCW / Medicaid / DPS / Other _____

Member Name _____ SSN or Member ID # _____ Member Date of Birth ___/___/___

Do you have any allergies to medications? Y / N If yes, please list _____

Do you take any medication? Y / N **List all medications you take including over the counter medication:** _____

Health Conditions Questions Please circle the appropriate answers

Do you or your Family Members have any of the following conditions P =Patient has this problem F = Family member has this problem

Lazy eye	P	F	Glaucoma	P	F	Macular Degeneration	P	F	Diabetes	P	F
Eye Surgery	P	F	Blindness	P	F	Retinal Detachment	P	F	Cancer	P	F
Crossed Eye	P	F	Cataract	P	F	Color Blindness	P	F	High Blood Pressure	P	F

Do **YOU** have problems in the following areas or do you have a history of problems in the following areas: Please Circle all that apply

Fever	Sinus Congestion	Genitourinary Problems	EYE CONDITIONS	
Weight Loss/Gain	Chronic Cough	Gastrointestinal Problems	Burning	Itching
Skin Conditions	Asthma	Muscle/Joint Pain	Redness	Discharge
Headaches	Chronic Bronchitis	Bleeding Problems	Dryness	Tearing
Migraines	Emphysema	Anemia	Flashes	Floaters
Seizures	Heart Pain	Rheumatoid Arthritis	Sties or Chalazion	
Thyroid/Other Glands	Vascular Disease	Multiple Sclerosis	Double Vision	
Allergies/Hay Fever	Psychiatric	Lupus	Blurry Vision	

Other Health Problems, Surgeries, Hospitalizations you have had: _____

Social History (This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

Yes, I would prefer to discuss my Social History information directly with my doctor

Do you use Tobacco products? Y N if yes, type/amount/how long? _____

Do you drink alcohol? Y N Do you use illegal drugs? Y N Have you been infected with HIV gonorrhea Hepatitis

When was your last eye exam? _____ What office? _____ Were you dilated? Y N

Are you currently pregnant or nursing? Y N Are you interested in LASIK? Y N

Do you currently wear contact lenses Y N Do you want contact lenses today? Y N

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 in most cases are included in this fee for up to three months. 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.

HIPAA Notice

I acknowledge that I have received a copy of One Hour Optical's Notice of Privacy Practices (available from our office front desk.) Additionally, 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.

Pupil Dilation Consent/Release

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 about 4-6 hours. People usually do not have problems driving after pupil dilation.

Please Initial: _____ I Accept Pupil Dilation _____ I Refuse Pupil Dilation

Patient Signature or Parent/Legal Guardian Signature if patient is a minor: _____ Date: _____