Welcome to Ottica Eyecare

COMPLETE FORM IN ENTIRETY

(Please Print)

Name_____ How long has it been since your last eye exam?_____year (s)

Street_____**Date of Birth**_____**Sex M or F**

City_____State_____ Zip_____Social Security Number_____

Cell_____ Home_____Work_____

Best way to reach you? Circle One Cell Home Work Text OK? Yes No

Email Address_____

Employer or School_____ Occupation_____

How did you hear about our office? Family member/friend—Who? Their name_____

____ Google/Internet ____Sign____ Insurance Booklet ____ Planet Fitness_____Other/how?_____

What is your main reason for your visit today?_____

Do you work/view a computer/phone/tablet more than 4 hours per day? Yes / No

Do you have neck/muscle aches at the computer? Yes / No

Do you currently have prescription sunglasses? Yes/No Computer Glasses? Yes/No Work/Safety Glasses? Yes/No

Do you have a current Medical Doctor (MD)? Yes No Name_____

Do YOU have any of the Following:

Please **CIRCLE** if **YES**

Diabetes
Cancer history
High Blood Pressure
Heart Disease
Arthritis
Thyroid Disease
Glaucoma
Double Vision
Macular Degeneration \
Cataracts
Lazy Eye/Amblyopia
Headaches

Are You Taking any Prescription Medications?

You DO NOT need to list medications

Yes or No

Do you smoke cigarettes/tobacco? yes___no___

Do you drink alcohol? yes____no____

Please list any Allergies below:

Do any of your BLOOD relatives have any of the following below:

Diabetes
Hypertension
Glaucoma
Macular Degeneration
Heart Disease
Stroke

Dilation of Pupils

Dr. Alton strongly recommends that your pupils are dilated to thoroughly evaluate the health of the inside of your eye. Since you are a current patient, your eyes do not have to be dilated at every visit unless you have symptoms that would require dilation. The drops may cause it to be bright outdoors, you can usually drive and they may affect your focusing at near for 3-4 hours**. Dilation can always be rescheduled at a more convenient time at no extra charge.**

Financial Responsibility

All charges and co-pays incurred today are the responsibility of the patient or parent at the time of service . If your insurance company has not paid us within 30 days, you will be sent a bill for the unpaid amount. Your insurance company is providing a service for you and it is not the responsibility of this office to secure payment from them. This is also your **"signature on file"** for us to receive insurance reimbursement payment.

ALL GLASSES AND CONTACT LENSES MUST BE PAID IN FULL BEFORE ORDERING.

I understand and accept financial responsibility for any charges incurred:_____ **Date**_____

We accept personal checks , cash, debit, credit, care credit for payment

NO MATERIALS OR PRESCRIPTIONS WILL BE RELEASED UNLESS PAID IN FULL
NO REFUNDS FOR SERVICES OR MATERIALS
All information on this sheet is personal and confidential including your email and will not be shared with anyone else unless you give your permission. All HIPPA rules and regulations apply.

PLEASE COMPLETE OTHER SIDE

ACKNOWLEDGEMENT OF NOTIFICATION OF PATIENT'S RIGHT TO PRIVACY

I acknowledge that I have been notified by Dr. Paul J. Alton/Ottica Eyecare Notification of Patient's Right to Privacy

Patient Name_____

Signature_____Date_____

To allow Dr. Paul J. Alton/Ottica eyecare to discuss your medical condition, treatment plan, surgery plan, appointment dates and times etc. with a family member or other person involved in your health care, please list their names and relationships to you below. You are not required to list anyone if you chose not to.

I authorized Dr. Paul J. Alton/Ottica Eyecare to release health information identifying me to the family member or other persons I have listed below:

Name_____Relationship_____

Name_____Relationship_____