Ocean Ranch OPTOMETRY

Welcome back! We look forward to helping you with your eye care needs.

Full Name: _____Preferred Name: _____ Birth Date: _____
Mailing Address: _____ City: _____ State: ____ Zip: _____
Email Address: _____ Cell Phone: _____ May we send you text message alerts? ☐Yes ☐No
What is the reason for today's visit? ☐Red Eye ☐Dry Eye ☐Itchy Eye ☐Blurry Vision ☐Floaters ☐Glasses ☐Contact Lenses ☐ Other

DIGITAL RETINAL IMAGES (DRI)

DR. SPAETH RECOMMENDS THAT ALL PATIENTS HAVE AN IMAGE TAKEN DURING THEIR EYE EXAM.

- Dr. Spaeth recommends having the Digital Retinal Image or dilation of the eyes.
- Enhanced view of your retina, vessels and optic nerve to evaluate your health.
- Early detection of **Glaucoma, Macular Degeneration, Diabetes, and Arteriosclerosis.**
- The image becomes a part of your permanent record.

THE FEE FOR THIS PROCEDURE IS $39.00 FOR BOTH EYES

☐ Yes, I would like to have digital retinal images taken for my records.

☐ No, I decline to have digital retinal imaging

OCULAR HISTORY

What other services are you interested in? ☐LASIK ☐Computer Glasses ☐Reading Glasses ☐Prescription Sunglasses ☐Driving Glasses ☐Contact Lenses
Are there any problems with your current glasses or contact lenses? _____

MEDICAL HISTORY

Please list any medications you are currently taking (including eye drops, oral contraceptives, aspirin, over the counter medications): _____
_____
Are you allergic to any medications? If yes, which ones: _____
List any **recent** surgeries and/or hospitalizations you have had: _____

ASSIGNMENT AND RELEASE

Please sign below for authorization of payment for contracted insurance plans and the release of any medical information necessary for your insurance company in conjunction with federal privacy laws. Our office will provide you with a thorough receipt for reimbursement of non-contracted insurance plans.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose health information in order to treat you, obtain payment for our services, and conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. **I acknowledge that I have received a copy of the office's Notice of Privacy Practices**

By signing below you acknowledge that you accept responsibility for payment of our services and materials you receive. Payment for professional services is expected at the time services are provided. We accept cash, check, Visa, MasterCard, American Express and Discover. Our policy regarding orders for materials is that we require a minimum of a 50% deposit at the time the order is placed and balance due upon delivery. All professional services are non-refundable. All material returns are subject to a 20% restocking fee.

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

☐ EX ☐ CTL EX ☐ CTL CHECK ☐ WEARING CTL ☐ OFFICE VISIT ☐ EMERGENCY OFFICE VISIT

NOTES FOR EXAM:

CONTACTS:
CURRENTLY WEARING:
BC: OD:
BC: OS:

TRIAL LENSES:
BC: OD:
BC: OS:

☐ ORDER TRIALS ☐ ORDER CTLS
☐1 WK F/U ☐OTHER _____

GLASSES:
Discussed:
1ST PAIR A/R: ☐ SV: ☐ PROG: ☐ BF: ☐ RX SUN: ☐
2ND PAIR A/R: ☐ SV: ☐ PROG: ☐ BF: ☐ RX SUN: ☐
CRT/ NVF A/R: ☐ SV: ☐ PROG: ☐ BF: ☐

☐ARMD ☐GLAUCOMA FOLLOW-UP: _____
☐DRY EYE ☐DIABETES
☐LASIK ☐BLEPHARITIS MEDICAL INS.: _____
☐RED EYE ☐OTHER _____ ☐DR. SPAETH ☐BILLING