



# C-GALT EYECARE

Please fill out the **FRONT** and **BACK** of this form as completely as you can.

## 1. PATIENT INFORMATION

Date \_\_\_\_\_  New Patient  Previous Patient

Name \_\_\_\_\_  
 First Middle Initial Last

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Guardian/Parent Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone # (\_\_\_\_\_) \_\_\_\_\_  
 mobile  home  work  other \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/School \_\_\_\_\_

Referred by  Friend  Insur.  Drive By  Web  Print

Exam Type?  Glasses  Contacts  Both

Reason for Today's Exam? \_\_\_\_\_

## 2. VISION INSURANCE (if applicable)

Member's Name \_\_\_\_\_

Member's Birthdate: \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Member's ID/SS # \_\_\_\_\_

Patient's ID# if different from above \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
 Name of Insurance Company(ies)  
 Dr. David Q. Le all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
PRINT name of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## 3. EYE HEALTH HISTORY

Date of last eye exam \_\_\_\_\_  
 Location \_\_\_\_\_

Check "Yes" or "No" to indicate if you have had any of the following:

Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Distance Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> All the time <input type="checkbox"/> Occasionally	Blurred Near Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Glare/Light Sensitive <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> Computer	Burning/Stinging Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Itchy Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
Age of present glasses _____	Discharge from Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
Computer use: _____ hrs/day	Distorted Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Sandy/Gritty Feeling <input type="checkbox"/> Yes <input type="checkbox"/> No
Type: <input type="checkbox"/> Rigid <input type="checkbox"/> Soft	Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No
Comfortable? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Infection/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos <input type="checkbox"/> Yes <input type="checkbox"/> No
Age of present contacts _____	Eye Pain/Soreness <input type="checkbox"/> Yes <input type="checkbox"/> No	Tired Eyes/Eye Strain <input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, are you interested in trying them?	Floating Dark Spots <input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe	Foreign Body Sensation <input type="checkbox"/> Yes <input type="checkbox"/> No	Watery Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No

**DILATION** An optional dilation is included as part of the comprehensive eye exam:

**PURPOSE:** Dilation allows greater viewing of the retina (back of the eye) to better evaluate the inside health of the eyes for disease.

**RECOMMENDED** for patients with: 1) 1<sup>st</sup> exam for baseline recording; 2) 2-3 years since last dilation; 3) age greater than 60; 4) visual fluctuations or unexplained vision loss; 5) extreme nearsightedness; 6) frequent headaches 7) recent onset of flashes or floaters; 8) self history or family history of hypertension, diabetes, glaucoma, macular degeneration, or retinal problems.

**SIDE EFFECTS** lasting 3-6 hours: 1) Blurred near vision; 2) Increased light sensitivity/glare; 3) Rare Cases of redness and sharp pain due to increased eye pressure (acute glaucoma). Disposable sunglasses will be provided for the increased light sensitivity.

**CHECK ONE:**

I understand the above and **consent** to have dilation done.

I understand the above and **decline** dilation at this time. I understand, however, that if I should have an underlying vision-threatening eye disease it may go undetected without a dilated exam.

Pt. Initials \_\_\_\_\_

## 4. MEDICAL HEALTH HISTORY

Medical Dr.'s Name \_\_\_\_\_ Medical Ins. \_\_\_\_\_

Last Medical Exam \_\_\_\_\_ Check "Yes" or "No" to indicate if you or a blood relative have had any of the following problems:

<b>Ocular Conditions</b>	<b>Yourself</b>	<b>Family Members</b>		<b>Yourself</b>	<b>Family Members</b>
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed/Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retinal Detachment/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines/Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Systemic Conditions</b>	<b>Yourself</b>	<b>Family Members</b>	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bell's Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant or nursing? _____		
Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use _____pk/wk    Alcohol Use _____drinks/day		
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been exposed or infected with: <input type="checkbox"/> NONE		
Cholesterol - High	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> gonorrhea <input type="checkbox"/> syphilis <input type="checkbox"/> herpes <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

### MEDICATIONS

List any medications you take (including eye drops, OTC, Vit., etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### ALLERGIES

List your allergies to medications or other substances:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any major injuries/surgeries: \_\_\_\_\_

## 5. RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FORM

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 this health information in order to treat you, obtain payment for our services and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** you have been given describes these uses and disclosure in detail. You are free to refer to this notice at any time before you sign this form. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

### Consent to Communicate Via E-mail/Text Messages - E-mail/Text Messages are not HIPAA Compliant

I voluntarily give my permission to C-Galt EyeCare Optometry to communicate with me or my child \_\_\_\_\_ via e-mail and/or text messages for business/healthcare purposes. This communication could include but is not limited to: appointment reminders, spectacle /contact lens 'pick-up' notifications, spectacle/contact lens prescriptions (by request), exam reports or evaluations, and patient review surveys. I give this permission understanding that e-mail/text messages may be unencrypted and therefore may not be secure. E-mail/text message contents and attachments may be read by unintended recipients.

**Circle One:** YES, I WANT or NO, I DO NOT WANT communication via e-mail/text messages.    **Patient / Guardian Initial:** \_\_\_\_\_

**I have read this document, understand it, and agree to it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from C-Galt EyeCare Optometry.**

Dr. initials/reviewed

Date

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Date