First Name _____ **Last Name**_____ **Date:**_____

Address: _____ **DOB**: ___/___/___
Street *City* *State* *Zip Code*

Home (____)_____ **Cell** (____)_____ **Email** _____

Insurance information: _____ Occupation: _____

Yearly appointment reminders are sent from Lakhani Vision Care via email and text.

Reason for Today's Visit	

Are you interested in a contact lens exam today? □ **Yes** □ **No**

If you are currently wearing contact lenses, please provide the following information: □ Not Sure of Brand or Power

Lens Brand/Name: _____ RIGHT POWER: _____ LEFT POWER: _____

Contact lens fittings are required each year to renew and receive an updated contact lens prescription.

Review of Systems: Please circle all condition(s) that apply to you

□ No Problems		□ Other _____				GI	Celiac Disease	Acid Reflux	Colitis	Crohn's Disease	Ulcer
BODY	Cancer	Fatigue Syndrome	Developmental Disability			GU	Pregnant	Nursing	Prostate Hypertrophy	Herpes	STD
ENT	Sinusitis	Laryngitis	Dry Mouth	Hearing Loss		MUSC/ SKELETAL	Osteoarthritis	Muscular Dystrophy	Gout	Ankylosing Spondylitis	Fibromyalgia
NEURO	Cerebral Palsy	Multiple Sclerosis	Stroke/CVA	Epilepsy	Migraines	SKIN	Rosacea	Eczema	Cold Sores	Psoriasis	Shingles
PSYCH	Depression	Bipolar	Attention Deficit	Anxiety Disorder		ENDO	Thyroid Dysfunction	Diabetes Type 2	Diabetes Type 1	Hormonal Dysfunction	
CARDIO	Vascular Disease	Stroke/CVA	Hypertension	Heart Failure	Heart Disease	BLOOD	Anemia	High Cholesterol	High Volume Blood Loss		
RESP	Emphysema	Chronic Obstruction	Bronchitis	Sleep Apnea	Asthma	ALLERGY	Lupus	Drug Allergies	Sjorgen's Syndrome	Rheumatoid Arthritis	Environmental Allergies

Medications: □ None List ALL medications including eye drops (Prescription or OTC) that you are currently taking

_____

_____

Allergies: □ None List ALL allergies you may have (medications, environmental, food, etc)

_____

_____

PAST OCULAR HISTORY: **Please circle all applicable eye conditions**

□ NONE	Strabismus	Retinal Holes	Retinal Detachment	Keratoconus
Cataracts	Glaucoma	Glaucoma Suspect	LASIK/Ocular Surgery	Macular Degeneration
Eye Patching	Amblyopia (Lazy Eye)	Injury	Other: _____	

SOCIAL HISTORY:

Do you drink? □ NO □ YES Amount _____

Do you smoke? □ NO □ YES Amount _____

Smoking Status: □ Never □ Former Smoker

□ Occasional □ Every day Smoker

FAMILY HISTORY **Please list immediate <u>family members</u> with these conditions: parents/grandparents/siblings/children**

Medical	Diabetes Type 1 or 2 _____	Cancer _____	Hypertension _____	Hyperthyroidism Hypothyroidism _____
Ocular	Macular Degeneration _____	Glaucoma _____	Cataracts _____	Other _____

Our office does not provide the pupillary distance (PD) with your eyeglass prescription. That will be measured by your dispensing optician.

<u>OFFICE USE ONLY</u>: NP / EP _____ GLS / CL OM / Dilation / Reschedule Dilation GL or CL / no Rx **VA:**

	Tech	**Dr.**	
INS:	R:	R:	
DISC: _____	L:	L:	**NCT:**
	ADD:	ADD:	

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

The privacy act was established by the government to protect all your medical information and requires us to inform you that your medical information is confidential, and we can only release it upon your request. By initialing, you are agreeing that you have been made aware of the Notice of Privacy Practices for Lakhani Vision Care, PC and a copy of such can be provided upon request.

Initials _____

ACKNOWLEDGEMENT OF OCULAR HEALTH EVALUATION

This office will make every effort to perform a complete retinal evaluation with each comprehensive eye exam. The internal ocular evaluation is an important component of a routine eye examination since many eye problems can develop without symptoms.

The internal ocular evaluation involves using dilating eye drops, which is included in the comprehensive exam at no charge. Be advised that you may experience blurred vision when reading and an increase in light sensitivity, which can remain for up to 4-6 hours. If today is not convenient, the dilation may be rescheduled at no charge. If you refuse to have your eyes dilated, you are assuming all risks associated with failure to diagnose eye conditions due to lack of information that may have been provided by this test. However, we also offer a non-contact wide view imaging system, Optomap, that allows the doctor to capture hi-res images of your retina which can be performed quickly and without any symptoms. This is an **additional $29.00 fee** for each patient. This can be further discussed on the day of your appointment.

I am OK with the doctor dilating my eyes □ YES □ NO

I would prefer the Optomap Retinal Pictures for an additional $29.00 □ YES □ NO

Initials _____

CONTACT LENS FITTING POLICY

(INITIAL ONLY IF YOU WEAR CONTACT LENSES)

Contact lenses are medical devices, and state law prohibits dispensing contact lenses without a valid prescription or after one year from the original date of the contact lens evaluation. Disposable trial lenses are for fitting purposes only and will be dispensed at the initial fitting of the prescription. The fitting fee includes follow-up visits for up to 2 MONTHS from the initial evaluation regardless of lens type or modality. If follow-up visits are needed after 2 months, additional office visit charges may apply.

Initials _____

PAYMENT FOR SERVICE AND INSURANCE CLAIMS POLICIES

Payment for all services will be collected at the end of the exam. Though our office staff will make every effort to verify your benefits, it is your responsibility to present adequate insurance plan information upon check-in, for verification, before payment is collected. If insurance information or other discount plans are not presented or verified upon check-in, it will be the patient's responsibility (or guardian's if patient is under 18 years of age) to self-file the claim with their respective insurance. Therefore, no discounts will be honored after services have been performed. All unpaid balances accumulated on an account for a period of more than 30-days will be forwarded to the collections department. My signature/initials indicate that I agree to be financially responsible for my bills, that I understand the charges, and that I am aware that payments for professional services are nonrefundable. I authorize the release of any medical or other information necessary to process my claim and I authorize payment of vision/medical benefits to Lakhani Vision Care.

Signature: _____