Solace Optometry

Patient Health History **Date**:_____

Name:		
Address:		
DOB & Age:		Email:
Phone:	Cell:☐ Home: ☐	How did you hear about us?
Occupation:		Hobbies:

Vision Insurance	Medical Insurance
Plan Name:	Plan Name:
Member ID:	Member ID:
Primary Person Insured:	Primary Person Insured:
Relationship to Insured:	Relationship to Insured:
Self:☐ Spouse:☐ Dependent:☐	Self:☐ Spouse:☐ Dependent:☐

Ocular History

Do You Wear Glasses? No ☐ Yes ☐ If yes, how old is your current pair of lenses? _____
Do You Wear Contact Lenses? No ☐ Yes ☐
If yes, what type: Rigid ☐ Soft ☐ Toric ☐ Multifocal ☐ Monovision ☐
Have you had refractive surgery? No ☐ Yes ☐ If yes, Surgical Date: _____ Type, if known: _____
What other services would you like to be evaluated for? Refractive Surgery ☐ Contact Lenses ☐
Computer Glasses ☐ Reading Glasses ☐ Sunglasses ☐ Driving Glasses ☐
Are you having any visual difficulties? _____ If yes, please explain:_____
_____

Are you currently experiencing any of the following problems with your eyes? Check the box if "Yes"

☐ Blurred Vision	☐ Flashes/Floaters in Vision	☐ Redness
☐ Loss of Vision	☐ Halos / Glare / Light Sensitivity	☐ Excess Tearing / Watering
☐ Loss of Side Vision	☐ Dryness	☐ Eye Pain or Soreness
☐ Distorted Vision	☐ Sandy or Gritty Feeling	☐ Mucous Discharge
☐ Double Vision	☐ Burning	☐ Eyelid Redness / Discomfort
☐ Tired Eyes	☐ Itching	☐ Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? Check the box if "Yes"

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment / Disease
☐ Crossed Eyes	☐ Lazy Eye / Amblyopia	☐ Dry Eye
☐ Eye Injury	☐ Macular Degeneration	Other:

Medical History

List any medications your are currently taking (include oral contraceptives, aspirin, and over the counter medications):_____
_____

Are you allergic to any medications? No ☐ Yes ☐ If yes, which medications:_____
_____

Do you use tobacco products? No ☐ Yes ☐ Do you use marijuana products? No ☐ Yes ☐

Are you pregnant or nursing? No ☐ Yes ☐ N/A ☐

Review of Systems

Constitution ☐ All Normal
- ☐ Cancer
- ☐ Developmental Disabilities

Ears/Nose/Throat ☐ All Normal
- ☐ Sinusitis
- ☐ Dry Mouth

Neurological ☐ All Normal
- ☐ Multiple Sclerosis
- ☐ Tumor
- ☐ Stroke / CVA
- ☐ Migraine

Psychiatric ☐ All Normal
- ☐ Depression
- ☐ Anxiety

Cardiovascular ☐ All Normal
- ☐ Hypertension
- ☐ Heart Disease

Respiratory ☐ All Normal
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Emphysema

Other conditions not listed:

Gastrointestinal ☐ All Normal
- ☐ Crohn's/Colitis/IBS
- ☐ Ulcer
- ☐ Acid Reflux

Genitourinary ☐ All Normal
- ☐ Kidney Disease
- ☐ Prostate Cancer
- ☐ Ovarian Cancer

Musculoskeletal ☐ All Normal
- ☐ Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Gout

Integumentary (Skin) ☐ All Normal
- ☐ Rosacea
- ☐ Cancer

Endocrine ☐ All Normal
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Thyroid Dysfunction

Hematologic/Lymphatic ☐ All Normal
- ☐ Anemia
- ☐ High Cholesterol

Allergy/Immunologic ☐ All Normal
- ☐ Rheumatoid
- ☐ Lupus
- ☐ Sjogren's Syndrome

Family History

Please note any family history (parents, grandparents, siblings, or children) for the following conditions:

	Relation to you		Relation to you
☐ Glaucoma		☐ Diabetes	
☐ Macular Degeneration		☐ Cancer	
☐ Retinal Detachment		☐ Heart Disease	
☐ Blindness		☐ Hypertension	
☐ Crossed Eyes		☐ Lupus / Arthritis	

Signature:_____ Date:_____

Solace Optometry

HIPAA Patient Consent

Our Notice of Privacy Practices provide information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.

The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

The Practice may condition receipt of treatment upon the execution of this Consent.

Please initial to acknowledge consent and sign at bottom of page.

Initials:____

Financial Policy

We are required to obtain your personal information, valid identification, and current insurance by federal law to prevent insurance fraud. You are fully responsible for the total payment of all procedures performed in this office – this includes any service / treatment that is not a benefit of any insurance that you may have. All non-insurance services and products are due to be paid in full at the date of service. It is our company policy to collect all co-pays and deductibles at the time of service. Balances on accounts are due 30 days from billing date. A 1.5% service charge will be applied per month on all unpaid balances past 30 days until paid in full.

Please initial to acknowledge consent and sign at bottom of page.

Initials:____

Contact Lens & Glasses Prescription Acknowledgment

Our office delivers contact lens and glasses prescriptions through our secure online patient portal. If you need assistance with accessing the portal, please ask our employees to assist you. If you choose not to use our secure portal, your prescription may be delivered through email or a printed copy. Sign below to acknowledge that you consent to receive your contact lens and/or glasses prescription at the completion of your contact lens fitting and exam through electronic means.

Printed Name:_____

Signature:_____ Date:_____