WELCOME TO OUR OFFICE

Patient _____ DOB ____/____/_____ Last 4 SSN _____

Address _____ City _____ State _____ Zip_____

Home phone _____ Mobile phone_____

Email _____ Work Phone _____

Employer _____ Occupation _____

Medical Insurance & ID _____ Vision Plan & ID _____

Emergency Contact _____ Phone _____ Relationship _____

HIPAA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the "Patient" or "Patient's Legal Representative", have been presented with the Notice of Privacy Policy of Dr. Bui, and have been offered a copy of such policy to keep for my records. *(Upon request, a personal copy of the policy may either be emailed or dispensed in person)*

ACCEPTANCE OF INSURANCE & FINANCIAL RESPONSIBILITIES

As a service, Dr. Bui's office verifies and files insurance claims on the behalf of their patients. However, I understand what may be quoted as my portion of financial responsibility (co-payment and/or co-insurance) is only an estimate provided by my insurance carrier. I agree to be responsible for what insurance does not cover for the services rendered. I realize that insurance benefits must be presented and verified at the time of service date. We cannot refund you for insurance benefits that were not verified at the time of service date.

Dr. Bui's office strives to guarantee their patients' complete satisfaction. Our doctors and staff promise to provide the best customer service possible, and to attempt to resolve any conflicts or concerns that may arise. However, I understand that all professional fees collected are ultimately non-refundable.

FOR CONTACT LENS PATIENTS

Your contact lens prescription will not be finalized until the doctor has checked your trial lenses to determine that they fit properly. In most cases, at least one follow-up visit is required in order to finalize your prescription, usually one week after your trials are dispensed. YOUR EXAM FEES INCLUDES THESE VISITS WITHIN 60 DAYS. **It is your responsibility to keep your follow-up appointment. It is a must you wear your trial contacts when you come in for your visit.** If your follow-up is more than 60 days after your initial visit, there will be a fee. The fees for contact lens services are as follows:

Type of Contact Lens Evaluation	Fee
Spherical & Astigmatism	$45
Monovision & Multifocal	$70
Rigid Gas Permeable	
RGP Multifocal	$90

Over 60 days – 6 months: $30

Over 6 months: The cost of a new examination.

By signing this form, I acknowledge and accept all of the above:

X_____

Signature of patient (or parent/guardian of minor) **Date**

EYE HISTORY

Reason for visit: ☐Glasses ☐Contact Lens ☐Eye infection or injury ☐Medical ☐Other: _____

Last Eye Exam: _____ Age of glasses: _____ Hours on computer/ digital devices: _____ daily

Current type of glasses: ☐Single Vision ☐Progressive ☐Bifocal ☐Tri-focal Have you ever worn contact lenses? ☐Yes ☐No

Current Contact Brand & Rx: (right) _____ (left) _____

Currently experiencing eye symptoms (please check all that apply):

☐ Blurred Distance	☐ Dryness	☐ Discharge/Matting	☐ Headaches
☐ Blurred Near	☐ Burning	☐ Excess Tearing/Watering	☐ Floaters
☐ Double Vision	☐ Itching	☐ Foreign Body Sensation	☐ Flashes of light
☐ Loss of Vision	☐ Redness	☐ Eye Pain or Soreness	☐ Light Sensitivity
			☐ Other:_____

Previous Eye Surgeries or Injuries: _____

PATIENT and FAMILY MEDICAL HISTORY

Self	Family/ Who?	
☐	☐	**NONE**
☐	☐	_____ Diabetes
		Type: ☐1 or 2☐
		How many years?_____
		Controlled? ☐Yes or ☐No
☐	☐	_____ High Blood Pressure
☐	☐	_____ Thyroid
☐	☐	_____ Heart Problems
☐	☐	_____ Lung/Respiratory Problems
☐	☐	_____ Cholesterol
☐	☐	_____ Rheumatoid Arthritis
☐	☐	_____ Multiple Sclerosis
☐	☐	_____ Gastrointestinal Problems
☐	☐	_____ Other:_____

Self	Family/ Who?	
☐	☐	**NONE**
☐	☐	_____ Glaucoma
☐	☐	_____ Macular Degeneration
☐	☐	_____ Cataracts
☐	☐	_____ Retinal Detachment/Disease
☐	☐	_____ Optic Nerve Disease
☐	☐	_____ Strabismus (eye turn)
☐	☐	_____ Amblyopia (lazy eye)
☐	☐	_____ Color Blindness
☐	☐	_____ Keratoconus
☐	☐	_____ Iritis
☐	☐	_____ Other: _____

For previous patients:
☐ **NO CHANGE SINCE LAST VISIT**

If you would like to explain more to any of the above or have a condition not listed:

_____

Current medication: _____

Medication Allergies: _____

Previous Surgeries: _____

Are you pregnant? ☐ No ☐ Yes, trimester_____ Nursing? ☐ No ☐ Yes

Tobacco used? ☐ No ☐ Former ☐ Yes, type/amount/frequency _____

Alcohol consumption? ☐ No ☐ Yes, amount/frequency _____

Who should we thank for referring you? _____

X _____

Signature of patient (parent/guardian of minor) Date

Dilated Fundus Exam

Dilation of the pupil is an important procedure that allows a more thorough examination of the interior health of the eye, which is essential to determine eye health. Eye drops are instilled in each eye to temporarily increase the pupil size. This allows a wider field of view so that the doctor can gather a more complete health assessment inside of the eyes.

The eye drops take approximately 20-30 minutes to take effect. Once your pupils are dilated, it is common to have sensitivity to light and blurred vision especially at near. Even with sunglasses, it may make driving home and continuing your day's activities difficult. It will require about 4 to 6 hours for vision to return to normal. During this time you must exercise caution when walking down steps, driving a vehicle, operating dangerous machinery, or performing other task that may present a risk of injury to yourself or others.

A side effect from the drops that rarely occur is angle closure. Symptoms of angle closure include ocular pain, redness, severe headaches, cloudy vision (halos around lights), vision loss, and/or nausea. If this occurs, PLEASE CONTACT THE DOCTORS AT OUR OFFICE OR GO TO THE EMERGENCY ROOM IMMEDIATELY.

The dilation an <u>included</u> procedure at the time of your examination.

YES _____ I consent to have the procedure performed, and I understand the risks and benefits of pupil dilation.

NO _____ I do not wish to undergo the dilation, but the risks and benefits of pupil dilation have been adequately explained to me.

Visual Fields Screening

The Visual field screening tests the integrity of the optic nerve pathway. It is a non-invasive computerized test which helps detect signs of glaucoma, retinal disease, and neurological disease (such as brain tumors, stroke, and optic nerve defects). It can also aid in determining causes of headaches.

The fee for visual field screening is <u>$20.00.</u> Most insurances do not cover this procedure.

YES _____ I consent to have the visual field screening.

NO _____ I do not consent to have the visual field screening.

Digital Retinal Photo Imaging

This test offers a non-invasive and painless way to digitally capture the central retina and its structures (the optic nerve, macula, blood vessels). A healthy retina is critical to vision and needs to be examined for problems such as macular degeneration, glaucoma, retinal tears/detachments, and complications from diabetes, high blood pressure, high cholesterol, etc. Many eye diseases cause slow structural changes over time. This permanent record gives your doctor a reference image to more accurately identify changes in your eye and allows for treatment of diseases at an earlier stage.

The fee for the Retinal Photography is <u>$20.00.</u> Most insurances do not cover this procedure.

YES _____ I consent to have retinal photographs taken.

NO _____ I do not consent to have retinal photographs taken.

By signing this form, I acknowledge that I understand all above:

X _____

Signature of patient (parent/guardian of minor) Date