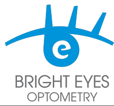


Bright Eyes Optometry
6910 S. Rainbow Blvd., Ste 102
Las Vegas, NV 89118

Patient Basic Information

Date: ______________
(Mrs./Ms./Mr./Dr.) ______
First Name ____
Last Name ____
Middle Name ____

Home Address ____
____
City __________________________ State ______________
Zip Code ____
Preferred Language ____
Race/Ethnicity ____

*How did you find us? (Yelp/Google?)__________________

Suffix (Jr., Sr.) ____
Cred (MD, DDS) ____
Nickname ____

Preferred Method of Communication* (circle one):
Email / Phone Call / Text Message

Email ____
Home Phone ____
Work Phone ____
Cell Phone ____

Other Information

Date of Birth ___________ / __________ / __________
SSN ____
Guarantor ____

Place of Employment ____
Occupation ____
Hobbies/Interests ____

Gender (circle one) **M** **F**
Patient Status (circle one) **New** **Returning**
Marital Status (circle one) **Single** **Married** **Divorced** **Domestic Partnership**

Name of Parent / Guardian (if patient is minor):
____

Vision Insurance Information

Insurance Company Name - PRIMARY ________________________ **SECONDARY** ________________________
Name of Insured ________________________ ________________________
Insured Social Security # ________________________ ________________________
Insured Date of Birth ________________________ ________________________
Policy/Member Number ________________________ ________________________
Group Number ________________________ ________________________
Relationship to Patient ________________________ ________________________

Medical Insurance Information

Insurance Company Name **PRIMARY** ________________________ **SECONDARY** ________________________
Name of Insured ________________________ ________________________
Insured Social Security # ________________________ ________________________
Insured Date of Birth ________________________ ________________________
Policy/Member Number ________________________ ________________________
Group Number ________________________ ________________________
Relationship to Patient ________________________

Pharmacy Name ____
Address ____
____
City _______________ State _____________ Zip _____________
Phone number ____
Fax number ____

Primary Care Dr ____
Address ____
____
City _______________ State _____________ Zip _____________
Phone ____
Fax ____

Reason for Today's Visit

Circle one: **Glasses** **Contacts** **Red Eye** **LASIK Consult**

OTHER (Blurry vision, eye pain, itchy eyes): ______________
____
____

Last Eye Exam Date ____

Currently contact lens wearer? **Yes** **No**
If Yes, how old is your present pair of contacts?__________________
Type of Contact Lens Brand/Type:__________________________
Are they comfortable? If no, explain:__________________________

Do you wear glasses? **Yes** **No**
What do you like about your glasses?__________________
What do you NOT LIKE about your glasses?______________
If Yes, how old is your present pair of glasses?______________

v20180608

Bright Eyes Optometry
Retinal Photography Consent Form

At **Bright Eyes Optometry**, we believe in offering the best possible care to all of our patients. As part of your annual eye exam, the doctor highly recommends **Optomap Retinal Exam** (**Retinal Photography)** be performed. This screening procedure consists of capturing a 200° Ultra-widefield high-resolution digital image of the retina in a single shot - without dilation. This is not an X-ray or an ultrasound procedure, and nothing will touch your eye. This image is immediately available for review with you and your eye doctor.

This permanent record is very valuable in assessing the current health of your eye and safeguarding the health of your retina, optic nerve, macula, and blood vessels. It will also serve an initial point with which to compare as we follow your health in subsequent years.

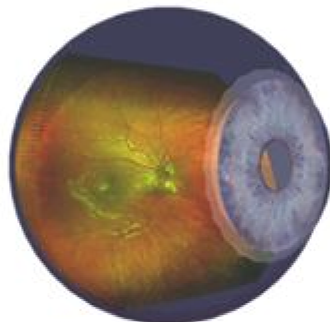
Retinal photography does not take the place of a dilated eye exam, and the doctor will advise you as to the necessity of a dilation in conjunction with your retinal photos.

Highly recommended for:

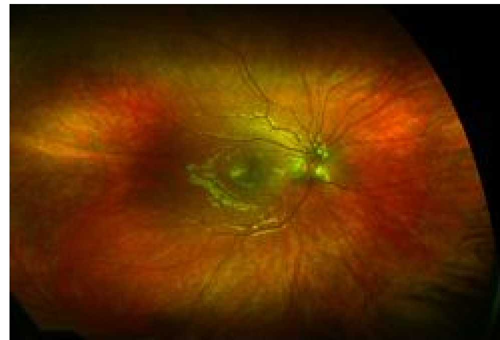
- Patients who have not dilated in the last year
- Patients who have moderate to high prescriptions
- Patients with diabetes or high blood pressure
- Patients over the age of 40
- Pregnant women
- Children afraid of eye drops
- Patients previously diagnosed with retinal disease
- Patients concerned about glaucoma risk
- A family history of ocular disease, such as macular degeneration or glaucoma.

Benefits

- Enlargement of image to see more detailed view of retina
- Takes just a few minutes to perform
- No vision blur after taking the image
- Creates a permanent record
- Allow for future comparisons year by year
- Can be reviewed by other doctors, if necessary



3D Wrap™ tool "wraps" the retinal image in an eye shape for patient comprehension



An optomap® ultra-widefield 200 degree view of a healthy retina

The Optomap will be performed annually as standard of care for every patient UNLESS a waiver is signed. There is a fee of $42 per photo session and your insurance may not cover the photos.

_____ **No, I decline to have an Optomap (digital retinal photography) performed.** I have been informed that a thorough internal examination of the eye is integral to an eye examination.

Patient Signature: ______________________________ **Date:** ______________

20180503

RELEASE OF LIABILITY FOR INTERNAL EYE HEALTH EXAM

Dilating the pupil with eye drops allows the doctor a much better view inside the eye to detect problems such as glaucoma, cataracts, retinal tears, macular degeneration, diabetes, and high blood pressure. Without the dilation, the doctor has a limited view of the interior of the eye and would not be able to detect any pathology that may occur in the far periphery of the eye. It is a standard for eye care that all patients receive this evaluation yearly. It is especially important for those patients who have not had a dilation performed in the last year, a history of diabetes, high blood pressure, headaches, flashes of light or floaters, moderate to severe nearsightedness, cataracts, or family history of glaucoma or retinal problems. For children, it is highly recommended to obtain additional data to help with final eyeglass prescription determination. Because side effects of the dilation involve light sensitivity and blurry vision, we do NOT recommend driving after dilation.

I have been informed that a thorough internal examination of the eye is integral to an eye examination.

□ I WOULD LIKE THE DILATION IF RECOMMENDED BY THE DOCTOR.

□ I DECLINE TO HAVE THE DILATION. **□ I WOULD LIKE TO HAVE THE OPTOMAP RETINAL PHOTO**

□ I WOULD LIKE TO RESCHEDULE THE DILATION FOR ANOTHER DAY.

Patient/Responsible Party Signature Date

PATIENT PRIVACY CONSENT

I have reviewed the HIPAA Notice of Privacy Practices (Laminated Form) and given the right to secure a copy of this form. I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1998 (HIPAA) and detailed in the Notice of Privacy Practices. I understand that by signing this consent I authorize Bright Eyes Optometry to use and disclose my protected health information LIMITED to:

- Treatment, including direct or indirect treatment by other healthcare providers involved in my care
- Obtaining payment from third party payers, i.e. my vision and/or medical insurance
- The day-to-day healthcare operations of Bright Eyes Optometry

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. Bright Eyes Optometry is not required to agree to these requested restrictions. However, if requested restrictions are agreed upon, Bright Eyes Optometry will comply with these restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date of revocation is not affected.

Patient/Responsible Party Signature Date

FINANCIAL POLICY AND CONSENT

I certify that the given personal and insurance information is correct to the best of my knowledge. I authorize and request my insurance company to pay directly to Bright Eyes Optometry. **I understand that my vision and/or medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for the full payment of all non-covered services rendered on my behalf or my dependents.** Bright Eyes Optometry only accepts VISA, MC, DISCOVER, AMEX, Care Credit and cash as forms of payment; personal checks are not accepted. In the event it becomes necessary to collect fees through litigation, the patient agrees to pay all collection fees, court costs, deposition fees, and reasonable attorney fees incurred.

Patient/Responsible Party Signature Date