



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

Place of Employment _____
Occupation _____
Hobbies/Interests _____

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

Vision Insurance Information

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

SECONDARY _____

Medical Insurance Information

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

SECONDARY _____

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
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: _____

OTHER (Blurry vision, eye pain, itchy eyes): _____

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? _____

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 RESCHEDULE THE DILATION**
- I WOULD LIKE TO HAVE THE OPTOMAP RETINAL PHOTO + iWELLNESS OCT SCAN**

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

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)** and **iWellness OCT** be performed as standard of care. The optomap screening procedure consists of capturing a 200° Ultra-widefield high-resolution digital image of the retina in a single shot - without dilation. The iWellness OCT scans subclinical layers of the retina that cannot be seen with normal examination techniques. These scans are NOT X-rays and nothing will be touching your eye. This photo and scan 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.

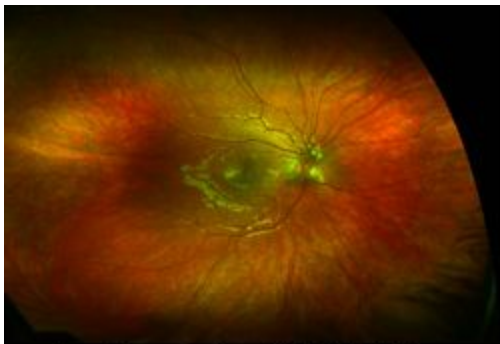
Retinal photography does not take the place of a dilated eye exam, and the doctor will advise you as to the necessity of a dilation in conjunction with your retinal photos.

Highly recommended for:

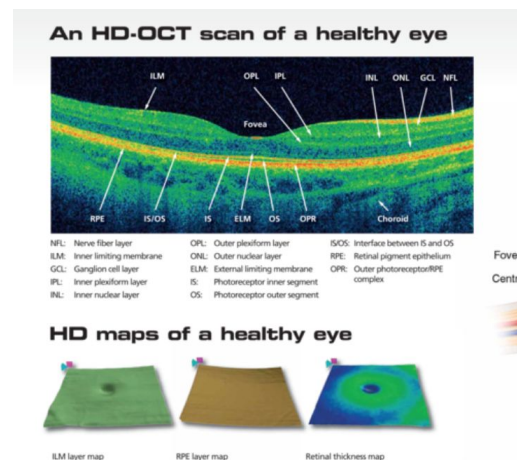
- Patients concerned about retinal disease, glaucoma, or macular degeneration.
- Patients who have not dilated in the last year
- Patients who have moderate/high prescriptions
- Patients with diabetes or high blood pressure
- Patients over the age of 40
- Pregnant women
- Children afraid of eye drops

Benefits

- **Comprehensive retinal evaluation**
- Takes just a few minutes to perform
- No vision blur after taking the image
- Non-invasive, does NOT touch eye
- Creates a permanent record
- Allow for future comparisons year by year
- Can be reviewed by other doctors, if necessary



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



The Optomap and iWellness OCT will be performed annually as standard of care for every patient UNLESS a waiver is signed. There is a fee of \$29 per scanning session and your insurance may not cover the photos.

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