OPTIC GALLERY
Family Eye Care

Patient Registration Form

PATIENT INFORMATION

Patient's Name_____ **Gender (M/F)**_____ **Age**_____ **Date of Birth** ____/____/____
Address_____ City_____ State_____ Zip_____
Phone# (Cell/Home)_____ Alternative Phone#_____
Married (Y/N)____ Employer/School_____ Occupation/Grade_____
Patient S.S.#_____ Patient Email_____

INSURED INFORMATION

Insured's Name_____ Insured S.S.#_____
Insured Date of Birth ____/____/____ Medical Insurance_____ Member ID#_____
Vision Insurance_____ Member ID#_____
Secondary Vision Insurance_____ Member ID#_____

VISION INFORMATION

Reason for Today's visit:_____
Last Eye Exam____/____/____ Where_____ Doctor_____
How were you referred to our office?_____
Do you wear contact lenses? (Y/N)_____ Type_____ Are you Interested in contact lenses? (Y/N)_____
List Activities/Hobbies_____

OCULAR HISTORY: Check all that apply: ☐ **I have No Ocular Conditions**

☐ Glaucoma ☐ Dry Eyes ☐ Eye Strain ☐ Watering ☐ Other _____
☐ Cataracts ☐ Blurred Vision ☐ Flashes ☐ Redness ☐ Trauma _____Date_____
☐ Macular Degen ☐ Double Vision ☐ Floaters ☐ Itching ☐ Surgery _____Date_____

Does anyone in your family have?
☐ Glaucoma ☐ Macular Degeneration ☐ Blindness ☐ Eye Disease ☐ Other

MEDICAL HISTORY: Check all that apply: ☐ **I have No Medical Conditions**

Medical Doctor_____ Last Visit_____ Phone_____

☐ Diabetes, Year_____ ☐ Kidney Disease ☐ Autoimmune Disease Do you: ☐ Smoke ☐ Drink ☐ Use Drugs
☐ Type 1 ☐Type 2 ☐ Sickle Cell ☐ Herpes/Shingles Frequency: _____
☐ High Blood Pressure ☐ Asthma ☐ Cancer _____ **Allergies:** _____
☐ High Cholesterol ☐ Sinus Problems ☐ Other _____ **Medications:**_____
☐ Heart Disease ☐ Allergies ☐ Surgeries_____ _____
☐ Thyroid Disease ☐ Headache ☐ Pregnant/Nursing (Y/N)_____ Est. Due Date:_____

Does anyone in your family have?
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Lung Disease ☐ Cancer ☐ Other

In the event that it becomes necessary for Optic Gallery to release and/or request your records from another healthcare professional, I authorize Optic Gallery, Dr. Justin Ng, Dr. Tracy Tran, or any of their associates to release and/or request these records. If applicable, I request that payment of authorized Medicare or other insurance be made either to me or on my behalf to Optic Gallery, Dr. Justin Ng, Dr. Tracy Tran, or any of their associates, or any services rendered to me. I authorize pertinent medical information about me to be released to healthcare financing or other insurance agencies for the purpose of determining insurance benefits and billing. I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY.

It is policy of this office to require:

1. **Payment in full is required before an order can be placed.**
2. **You are ordering a custom product made specifically for you. Orders cannot be canceled or changed once they are in progress.**
3. **NO RETURNS OR REFUNDS ON ANY ITEMS OR SERVICES. ALL SALES ARE FINAL.**

PRINT PATIENT'S NAME: _____

PATIENT/GUARDIAN'S SIGNATURE:_____ **Date**_____

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Privacy & Medical Consent Form

Print Patient's Name: _____

PATIENT PRIVACY NOTICE SUMMARY:

Earning and maintaining your trust and safeguarding your privacy is the cornerstone of our patient relationship with you as a patient. Protecting your privacy is a key part of maintaining your trust. This has been a fundamental operating principle of Optic Gallery Pahrump since our founding, and remains so today. This Patient Privacy Notice Summary informs you that we maintain strict internal policies regarding the confidentiality of Protected Patient Information (PPI). We implement physical, electronic, and procedural safeguards that comply with federal guidelines to protect patient information. Our employees are bound by these policies and may access patient information only for legitimate clinical and/or business purposes, and must keep such information confidential at all times. We pledge to do all we can to protect your privacy. If you have any questions about our privacy policy, or about how your information is maintained, safeguarded, or used please contact our Privacy Officer, Trudie Lee, at (702) 938-2020. Signing this section signifies that you have read and received a copy of our Notice of Privacy Practices.

Patient/Guardian's Signature _____ Date _____

MEDICAL SERVICES CONTRACT:

I hereby authorize and consent to medical treatment by Optic Gallery Pahrump for me (or my child). I authorize Optic Gallery Pahrump to release my (or my Dependant's) medical records to our family doctor, any insurance company adjuster, attorney, authorized agent working on behalf of Optic Gallery Pahrump, or other authorized parties. I understand that I am responsible for payment of all vision and medical treatment rendered to me by Optic Gallery and I agree to pay all co-payments, deductibles, and non-covered services at the time of visit. I understand that, as a courtesy, Optic Gallery Pahrump will file a claim with my insurance carrier, and I authorize payment directly to Optic Gallery Pahrump for the benefits otherwise payable to me under the terms of my insurance coverage. I understand that I am responsible for maintaining current coverage information to meet filing deadlines and for the payment of any remaining balance after my insurance carrier has processed the claim.

Patient/Guardian's Signature _____ Date _____

CONSENT FOR DILATION OF THE EYES:

In order to perform a thorough and complete ocular examination, it will be necessary for us to dilate your pupils. Dilation allows the doctors at Optic Gallery Pahrump to obtain a better view of the back of the eye. Many medications, vitamins, and foods can influence the health of your eyes and vision. Diseases such as High Blood Pressure, Diabetes, Arthritis, Auto-immune disorders and many other conditions can affect our ocular health and vision. Dilation specifically allows us to examine the Optic Nerve, Blood Vessels, Macula and peripheral Retina in greater detail.

Side effects of dilation include **blurry vision – both at distance and near – and light sensitivity for approximately 4-6 hours.** Our Doctors strongly recommend caution when driving or operating equipment or machinery after dilation. Signing below signifies that you have been informed of the risks and benefits of dilation. <u>You also understand that having your eyes dilated will add a minimum of 30 minutes or more to your examination.</u> Please select one of the options below:

- _____ I **WISH** to have my eyes dilated today
- _____ I **DO NOT** wish to have my eyes dilated and I accept full responsibility for having an eye exam without dilation
- _____ I wish to **DISCUSS** dilation with the doctor before making a decision
- _____ I wish to **RESCHEDULE** the dilation for another day

Patient/Guardian's Signature _____ Date _____

ELECTRONIC COMMUNICATION:

I give permission to be in contact via text message, email, and/or the Patient Portal through our Electronic Medical Records System.

Patient/Guardian's Signature _____ Date _____

OPTIC GALLERY
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Eye Wellness Consent Form

Eye Wellness Preventative Care
Digital Retinal Photography & OCT Retinal Scan

As part of your eye exam, the doctors at Optic Gallery recommend advanced diagnostic imaging to better assess the health of your eyes. Sight-threatening diseases, such as **glaucoma, macular degeneration, diabetic retinopathy, and others, often have no outward signs or symptoms**. A comprehensive examination, including a thorough retinal evaluation, is essential to protect your vision. To provide a more advanced assessment, Optic Gallery has incorporated the **Eye Wellness Exam** which includes **Digital Retinal Photography** (a retinal photo of the back of the eye) and **Optical Coherence Tomography** (OCT, a CT scan of the back of the eye). The digital photos evaluate the optic nerve, blood vessels, and tissues of the back of the eye. They also serve as a baseline for comparison in future years.

The Eye Wellness exam is highly recommended for all of our patients, especially those over the age of 40, those with any of the following diseases, or anyone with a family history of:

- Diabetes
- High Blood Pressure
- Heart Disease
- Cataracts
- Glaucoma
- Headaches
- Age Related Macular Degeneration (AMD)
- Symptoms of Flashes and/or Floaters
- High Nearsightedness

The doctor will review these high advanced tests with you during your examination today. These tests will become part of your permanent patient record. The **cost of the Eye Wellness examination is $49,** (some vision and medical insurances will cover a portion of the examination). Any questions you have about these tests can be discussed at your examination with your Doctor.

Please choose one of the following options:

_____ I **WISH** to have the Eye Wellness examination done today
_____ I **DO NOT** wish to have the Eye Wellness examination done today
_____ I wish to **DISCUSS** the Eye Wellness examination with the doctor before making a decision
_____ I wish to **RESCHEDULE** the Eye Wellness examination for another day

Patient's Name _____ Parent/Guardian's Name _____

Patient/Guardian's Signature _____ Date _____