DIAMOND OPTOMETRY

Patient Information

Last Name _____ First Name _____ MI _____

Name of Legal Guardian (if under 18) _____

Date of Birth _____ Age _____ SSN _____-_____-_____ Gender M / F _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____-_____-_____ Email Address _____

Emergency Contact _____ Relationship _____ Phone # _____-_____-_____

Referred by _____ Preferred Language _____

Insurance Information

Name of Vision Insurance _____ Member ID _____

Primary Member's Name _____ Birth Date _____

Primary Member's SSN _____-_____-_____ Relation to Patient _____

Name of Medical Insurance _____ HMO or PPO? _____

Patient Medical & Ocular History

When was your last eye exam? _____ What is your occupation? _____

Reason for today's exam ☐ Glasses ☐ Contacts ☐ Ortho-K ☐ LASIK Consult ☐ Other _____

Do you wear glasses? ☐ Yes ☐ No How old? _____ Do you have back up glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No Brand _____

Have you had any type of: ☐ eye injuries or ☐ eye surgeries? Please describe _____

Please check the box if <u>you</u> have any of the following medical conditions: ☐ No changes since last exam

☐ Diabetes (Type 1 / 2) ☐ Hypertension ☐ Heart Disease ☐ High Cholesterol

☐ Stroke ☐ Thyroid Disease ☐ Asthma ☐ Headaches

☐ Cancer ☐ Other _____

Please check the box if <u>you</u> have or have had any of the following ocular conditions: ☐ No changes since last exam

☐ Double Vision ☐ Flashes/Floaters ☐ Dry Eyes ☐ Crossed eye/Lazy eye ☐ Light Sensitivity

☐ Glaucoma ☐ Retinal Detachment ☐ Cataracts ☐ Macular Degeneration ☐ Other Retinal Disease

☐ Other _____

Any <u>family</u> history of the following conditions? If yes, who?: **M (mother) F (father) GM (grandma) GP (grandpa)**

☐ Diabetes ____ ☐ Hypertension ____ ☐ Heart Disease ____ ☐ High Cholesterol ____ ☐ Thyroid Disease ____

☐ Cancer ____ ☐ Glaucoma ____ ☐ Retinal Detachment ____ ☐ Cataracts ____ ☐ Macular Degeneration ____

☐ Crossed eye/Lazy eye ____

Please list your **current medications**: _____

Are you **allergic** to any type of medications? If yes, please list: _____

Females Only: Are you pregnant and/or nursing? ☐ Yes ☐ No

Social History: ☐ Smoker ☐ Alcohol ☐ Recreational Drugs ☐ Tobacco

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Use of Phone Number & Email Address

Notice of acknowledgment that text messages and emails sent and received will be solely for office use tasks such as appointment confirmation/reminders and order status updates.

I permit Diamond Optometry to email, text, and/or leave a message with my private information.

Refunds/Exchanges/Cancellations

I understand that refunds, exchanges, or cancellations must be requested within 24 hours of service for in-store credit only with a 20% restocking fee. There are no refunds on exam fees.

Responsibility of Payment

I understand that payment is due on the day of service. I authorize payment of medical benefits to the undersigned physician or supplier of services received. I understand that if my insurance fails to cover any or all of the services or materials received, I am fully responsible for payment.

Notice of Privacy Practices (HIPAA)

The undersigned patient or legally authorized representative of the patient acknowledges that he or she has received a copy of Diamond Optometry's Notice of Privacy Policies on the date indicated below. Copies are also located at the front desk.

Patient Name (printed): _____

Legal Guardian Name (if patient under 18): _____

Patient/Legal Guardian Signature: _____

Date: _____

DOCTOR'S USE ONLY

Billing Code **1 2 5 6 13 14 15 17** **Retinal image 4 (Y / N)** _____ **Make family appts**

Pt Condition: ☐ Diabetes ☐ Hypertension ☐ High Cholesterol ☐ Diabetic Retinopathy ☐ None

Diagnosis: ☐ Myopia ☐ Hyperopia ☐ Presbyopia ☐ Astigmatism ☐ Others: _____

GLASSES:

Usage:	**Type:**	**Material:**	**Other:**
Full Time	Single Vision	Polycarbonate	Transitions
Distance	Bifocal	Hi-Index 1.66	AR
Near	Progressives	Hi-Index 1.74	Blue-Light
Computer	Computer		Polarized
Over Cls	Digital (Eyezen)		

R _____ Add: _____

L _____

Second pair: _____

CONTACTS: _____ **Ready to order** _____ **Follow-up appt needed** _____ **Order trials**

CL Brand/Rx R _____

L _____

FOLLOW UP: _____ **weeks/months** **FOLLOW UP TYPE:** _____ Contact Lens _____ Medical _____ Glaucoma _____ Ortho-K

Testing Needed: _____ DFE _____ OCT _____ DRI _____ VF