PACIFIC OPTOMETRY GROUP Patient History Form

Date ____/____/_____

Patient Name (Last, First): _____

Address: _____ **Date of Birth:**_____/_____/_____**Gender:**M☐F☐Other☐

City/State/Zip: _____,_____,_____ **SSN:** _____–_____ –_____

Cell Phone: (_____)_____ **Employer:** _____

Home Phone: (_____)_____ **Emergency Contact/Relationship:** _____

E-Mail: _____ **Emergency Contact Phone:** _____

Occupation: _____ **Race/Ethnicity:** _____

General Health History (Check all that apply) **Date of Last Physical Exam:** ____/____/_____

Seasonal Allergies ☐ Hypertension ☐ Heart Disease ☐ High Cholesterol ☐ Thyroid Disease ☐

Digestive Problems ☐ Urinary Disorder ☐ Autoimmune Disorder ☐ Skin Disorder ☐ Blood Disorder ☐

Arthritis/Back Pain ☐ Neurologic Disorder ☐ Psychiatric Disorder ☐ Asthma ☐

Diabetes (Date of Diagnosis): _____ Type I ☐ Type II ☐ **Currently Pregnant or Nursing?** Yes ☐ No ☐

Surgical History (with dates): _____

Other Health Issues (Please Specify): _____

Eye and Vision History (Check all that apply) **Date of Last Eye Exam:** ____/____/_____

Glaucoma ☐ Cataracts ☐ Keratoconus ☐ Lazy Eye ☐ Macular Degeneration ☐

Eye Injury ☐ Eye Infection ☐ Eye Surgery ☐ Floaters ☐ Retinal Detachment ☐

Eye Allergies ☐ Dry Eye Color Deficiency ☐ Pterygium ☐ Diabetic Retinopathy ☐

Other (Please Specify): _____

Surgical History (with dates): _____

Do you wear glasses? Yes ☐ No ☐ Date of Prescription: _____ Use: Distance ☐ Near ☐ Computer ☐

Do you wear contacts? Yes ☐ No ☐ Date of Prescription: _____ Type/Brand: _____

Are you interested in LASIK? Yes ☐ No ☐

Medications: _____

_____

Allergies: _____

Smoking Status: Never Smoker ☐ Former Smoker ☐ Occasional ☐ Everyday ☐ *Years Smoked:* _____

Family History

Hypertension Relationship: _____ Glaucoma Relationship: _____

Diabetes Relationship: _____ Cataracts Relationship: _____

Thyroid Disease Relationship: _____ Macular Degeneration Relationship: _____

Cancer Relationship: _____ Keratoconus Relationship: _____

Vision Insurance: _____ **Insurance ID:** _____

Medical Insurance: _____ **Insurance ID:** _____

Name of Insured: _____ **Relationship to patient:** _____

Insured DOB: _____ **Insured SSN:** _____–_____–_____

I certify that my responses on this form are accurate and to the best of my knowledge. I understand that fees for services are due at the time they are rendered. I understand that I am responsible for the amounts not covered by my insurance. I authorize Pacific Optometry Group to bill my insurance company for my services today. I authorize Dr. Zhao/Dr. Park to examine my eyes or the eyes of my minor child. I understand any changes to the original order must be done within 60 days from the pick-up date and has a $40 processing fee; replacement lenses under warranty have a $40 processing fee, and no refunds on deposits after 60 days from the order date.

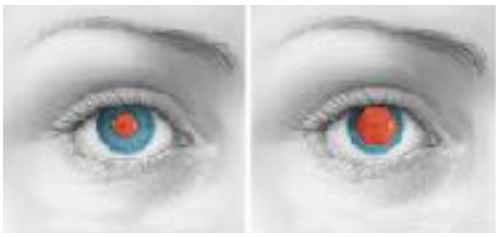
All information disclosed on this form is strictly confidential and conforms to HIPAA regulations.

Printed Name of Patient or Guardian **Signature of Patient or Guardian** **Date**

About Dilation

Pacific Optometry Group provides comprehensive eye care, which means checking both your vision and your eye health. Performing ***a dilated eye exam allows us to assess your internal eye health.***

What is a Dilation?



An undilated pupil on the left versus a dilated pupil on the right

A dilation is a procedure in which ***we use eye drops to enlarge the pupils***. This allows us to have a better view inside of the eyes to detect problems that we may not be able to see otherwise.

The eye drops require about ***15-20 minutes*** to reach their full effect, and your eyes may remain dilated for ***up to 4-6 hours***. While your pupils are dilated, you may experience ***blurred vision and light sensitivity***. It is never recommended that you drive while your eyes are dilated, and if you must be outdoors, tinted glasses with UV protection is required.

Who Needs a Dilation?

All patients are recommended to have a dilation at their first visit and every 1-2 years after that. Anybody with diabetes or other high-risk health conditions generally may need to be dilated more often than that. A dilation may be required to determine the cause of certain symptoms, such as floating spots in your vision, visual light flashes, blurry vision, or headaches.

Retinal Imaging

Pacific Optometry Group is pleased to offer the latest technology in retinal imaging, the iCare EIDON widefield TrueColor confocal fundus imaging system. This instrument will enhance our ability to detect and monitor retinal defects associated with common systemic diseases such as hypertension, diabetes, high cholesterol, stroke, and thyroid issues. Through this digital imaging of the retina, we can also observe early changes in the eye relating to glaucoma, cataracts, macular degeneration, and more.

Retinal Imaging of the Left Eye

This technology is now our standard of care.

Our doctors recommend this for all patients and also recommend having the scan repeated every 1-2 years depending on your age and risk factors for eye disease. Retinal imaging is optional and not covered under insurance. **The fee for retinal imaging is $34.00** and adds less than 5 minutes to the duration of your comprehensive eye exam.

Retinal imaging is available to all patients. We encourage everybody to get screened with this amazing new technology!

Dilation and Retinal Photo Consent

By signing below, I acknowledge that I have read the information regarding dilation and am making an informed decision regarding the dilation procedure. Furthermore, I attest that I fully understand and take responsibility for the risks of having or not having the dilation procedure. If I have chosen to schedule my dilation for a later date, I understand that it is my responsibility to do so and am assuming all risks of deferring the procedure.

Additionally, I understand that potentially blinding or deadly eye disease may be undetected without retinal imaging. I hold the staff and doctors at Pacific Optometry Group harmless for any eye disease that would otherwise have been detected with retinal imaging. I acknowledge that I have read and understood the retinal imaging handout.

_____

Please mark your choice regarding dilation below:

___ Yes, I would like to have my eyes dilated today.

___ No, I decline the dilation.

___ I would like to schedule my dilation for a later date.

_____

Please mark your choice regarding retinal imaging below:

___ YES, I'd like to proceed with retinal imaging as recommended by my doctor

___ NO, I'd like to decline retinal imaging and understand that by declining this procedure it may limit the doctor's ability to optimally assess my ocular health

_____ _____

Signature of Patient or Guardian/Representative Date

Pacific Optometry Group

12302 Garden Grove Blvd, Ste 6, Garden Grove, CA 92843 • Ph: (714) 590-2020 •
Website: pacificoptometry-group.com • email: pacificoptometrygroup@gmail.com

Patient Name: _____ DOB: ____/____/_____

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. You are free to refer to the notice at any time before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor or processing claims or obtaining payment; (2) our submission to claim to third-party payers and insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Pacific Optometry Group may change the **Notice of Privacy Practices** as needed.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, obtain payment for our services, and to perform health care operations. You also signify that you have received a copy of your **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or health care operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** described how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations. I acknowledge that I have received the **Notice of Privacy Practices** from PACIFIC OPTOMETRY GROUP.

_____ _____

Signature of patient or authorized representative Date

For Office Use Only

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.

I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for Simply Optometry but was unable to for the following reason:

- Patient refused to sign
- Patient is unable to sign
- Other _____

_____ _____ _____

Signature of Employee Employee Name Date