NEW PATIENT FORM

Advanced Family Eye Care Optometry
22809 Hawthorne Blvd, Torrance, CA 90505

PATIENT INFORMATION:

Name: D.O.B.:

Address: Home #

City, ZIP: Work #

E-mail: Cell #

Social Security: Marital Status: Race/Ethnicity:

Employment status: Employer: Occupation:

***Would you like to be contacted**: by phone, text, or email?* _____

Preferred Pharmacy (phone and address): _____

How were you referred to our office? □ Friend/Physician: _____
□ Google □ Yelp □ Facebook □ Office Website □ Other: _____

Do you wear glasses? □ Yes □ No Do you wear contacts? □ Yes □ No

Are you interested in contacts? □ Yes □ No Are you interested in LASIK? □ Yes □ No

INSURANCE POLICY HOLDER (if different than patient):

Name: D.O.B.:

Patient relationship:

Address: Home#

City, Zip: Work#

E-mail: Cell #

Social Security: Employer:

PATIENT GUARDIAN (if different than patient and insurance policy holder):

Name: D.O.B.:

Patient relationship: Home #

Address: Work #

City, Zip: Cell #

Social Security: Marital Status:

Employment status: Employer: Occupation:

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PLEASE READ THE BELOW AGREEMENTS CAREFULLY; YOUR SIGNATURE IS ACKNOWLEDGEMENT AND AGREEMENT.

POLICIES & PROCEDURES, FINANCIAL AGREEMENT AND POLICY:

I understand and agree that I am fully responsible for the total cost of all procedures and services performed at this office. I will make in-full & prompt payments, including any unmet deductibles and copayments. **Deposits for materials not picked up within 90 days will be forfeited**. ***All transactions are final. No refunds.***

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM:

I have read and understood the Notice of Privacy Practices from Advanced Family Eye Care. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

APPOINTMENT RESERVATION POLICY:

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible and no later than 2 business days before your scheduled appointment. Patients who no-show or cancel/ reschedule an appointment without a 2 business days notice will be charged a $25 fee for weekday appointments and a $50 fee for a Saturday appointment.

YOUR SIGNATURE BELOW IS AN AGREEMENT AND ACKNOWLEDGEMENT OF THE ABOVE POLICIES AND FEE AGREEMENTS.

Patient/Guarantor Signature: _____

Date:_____

I-WELLNESS SCAN RELEASE OF LIABILITY AUTHORIZATION:

Doctors recommend that all patients have the inside of their eyes health evaluated annually to detect any eye health diseases. This procedure will not cause blurry vision or side effects, results are reviewed at the same visit.

I-Wellness Scan: Two picture images **(similar to an ultrasound or X-ray**) can show **drusen, abnormal bleeding, scar tissue, Macular Degeneration, Glaucoma, Diabetes, High blood pressure & Cholesterol.**

Your copay would be $39.

□ **Yes, I agree** □ **No, I decline to have the health of my eyes examined today**

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Medical and Ocular History

Last Eye exam:_____

Past eye surgeries include dates:_____

List any eye/ocular conditions:_____

List current prescription or over-the-counter eye drops:_____

List any current medications and supplements:_____

List any known allergies:_____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ None

List any major injuries, hospitalizations, or other surgeries:_____

Family History

Please check all conditions that apply. (Parents, siblings, children, maternal/paternal grandparents: living or deceased)

Macular Degeneration □_____ **Glaucoma** □_____
Retinal Detachment □_____ **Diabetes** □_____
High Blood Pressure □_____ **Cancer** □_____
Heart Disease □_____ **Arthritis** □_____
Other:_____

Social History

Do you smoke? □ No □ Yes If yes, amount / how long:_____
Do you drink? □ No □ Yes If yes, amount / how long:_____
Do you use narcotics? □ No □ Yes If yes, please define:_____

Review of Systems

Do you currently or have you ever had any problems in the following areas (check all that apply):

Ears, Nose Mouth, Throat	□Allergies	□Sinus Congestion	□Runny Nose
	□Post Nasal Drip	□Dry Mouth/Throat	□Chronic Cough
Constitutional	□Fever	□Extreme Weight Loss/Gain	
Neurological	□Headaches	□Migraines	□Seizures
Endocrine	□Thyroid/Other Glands	□Diabetes/Gestational Diabetes	□Pre-diabetes
Genitourinary	□Kidney Disease	□Bladder/Genitals	
Gastrointestinal	□Diarrhea	□Constipation	
Bones/Joints/Muscles	□Arthritis	□Muscle Pain	□Joint Pain
Respiratory	□Asthma	□Emphysema	□Chronic Bronchitis
Vascular/Cardiovascular	□High Blood Pressure	□High Cholesterol	
	□Heart Pain	□Vascular Disease	
Lymphatic/Hematologic	□Anemia	□Bleeding Problems	

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PLEASE READ THIS CONTACT LENS FINANCIAL AND POLICY AGREEMENT CAREFULLY.

Contact lenses are medical devices that rest on the surface of the front of the eyes. Because the shape and prescription of the eye can change, we require additional annual testing and evaluation of the contact lenses on your eyes to check the fit and vision before releasing a prescription. This contact lens evaluation and fitting process is a professional service separate from your annual eye examination. Fitting exams and evaluation fees are based on the complexity of your prescription and lifestyle needs, affecting the contact lens fitting levels the doctor determines. Contact lens prescriptions are valid for one year from the date of the finalized prescription. **The contact lens evaluation/fitting fees are below**:

Soft Contact Lenses	**up to $315.00**, including 2 follow-up visits within 30 days from the initial visit.
Rigid Gas Permeable lenses, Scleral lenses & Custom contacts	**$1,000 to $2000.00**; includes 5 follow-up visits within 30 days from the initial visit.
Contact lens insertion & removal training for first-time wearers or established re-training	**$30.00**

You must return to the office for contact lens follow-ups. Be sure to wear the contact lenses that you received from this office when you return for your follow-up visit.

Additional contact lens follow-up exams are **$45** per visit. Office visits outside the prescribed timelines will be subject to additional exam fees. All professional fees must be paid promptly on the date of service.

Lenses purchased cannot be returned or exchanged after **30 days**. Contact lens boxes must be unopened and unmarked for return to the manufacturer. Custom orders cannot be returned and will not be refunded.

Advanced Family Eye Care Optometry is not responsible for the accuracy or quality of lenses purchased outside the office. Patients who purchased outside the office are not eligible for courtesy contact lens replacements.

Deposits for material not picked up within 90 days will be forfeited, no refunds are available.

I have read, understand, and agree to the above policies and fee agreements:

Print Name: _____
Signature: _____
Date: _____