FAMILY VISION OF OREGON, P.C.

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51675 N. Columbia River Hwy., Scappoose, OR 97056 (503)543-6313 FAX (503)543-6349

PATIENT INFORMATION

Last name:_____
First name:_____M.I._____

Date of birth:_____Gender: M F
Mailing address:_____
City:_____State:_____Zip:_____

Home phone:_____
Work phone:_____
Cell phone:_____
Email address:_____

Preferred language:_____
Race:_____
Ethnicity:_____

Patient's SSN:_____
Employer (or school):_____
Occupation (or grade):_____

May we leave detailed voice messages on your phone? YES NO

May we email you with appointment confirmations or other reminders? YES NO

May we text you with appointment confirmations or other reminders? YES NO

Spouse (or guardian's) name:_____
Spouse (or guardian's) employer:_____

NOTICE OF PRIVACY PRACTICES

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, obtain payment from insurance companies, or refer you to another physician. The full copy of the notice of privacy practices describes the uses and disclosures in detail. I acknowledge that I have received a copy of the Notice of Privacy Practices for Family Vision of Oregon, P.C.

Patient's (or guardian's) signature:

X_____**Date:**_____

INSURANCE INFORMATION

Vision Insurance:_____
Subscriber's name:_____
Subscriber's ID#:_____
Subscriber's birth date:_____

Primary Medical Insurance:_____
Subscriber's name:_____
Subscriber's ID#:_____
Subscriber's birth date:_____

FINANCIAL POLICY

Please be advised that if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Family Vision of Oregon, P.C.

I authorize my insurance benefits to be paid directly to Family Vision of Oregon, P.C. I understand I am financially responsible for non-covered materials and services. Additionally, I authorize the doctor and staff at Family Vision of Oregon, P.C. to release any and all information required to process the claim.

I understand due to the custom nature of our products we do not offer refunds. Any modifications to your eyewear order must be made within 90 days of purchase.

Patient's (or guardian's) signature:

X_____**Date:**_____

THANK YOU FOR CHOOSING OUR OFFICE!

Whom may we thank for referring you to our office?_____

If you were not referred, how did you choose our office?

- ☐ Another doctor
- ☐ Insurance list
- ☐ Saw sign/building
- ☐ Yellow pages
- ☐ Website

PATIENT INFORMATION

Primary Care Physician:_____
Date of last physical:_____
Height:_____
Weight:_____

Medications:_____
_____
_____
_____

Allergies:_____
_____

PATIENT'S MEDICAL HISTORY

Have you ever been diagnosed or treated for any of the following health problems?

	YES	NO
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph disorders	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive disorders	☐	☐
Ear/nose/throat disorders	☐	☐
Endocrine disorders	☐	☐
Fatigue	☐	☐
Genitourinary disorders	☐	☐
High blood pressure	☐	☐
Kidney disease	☐	☐
Muscle/bone conditions	☐	☐
Neurological disorders	☐	☐
Psychological conditions	☐	☐
Respiratory conditions	☐	☐
Sinus conditions	☐	☐
Skin conditions	☐	☐
Thyroid conditions	☐	☐
Unusual weight loss/gain	☐	☐

Do you use tobacco, alcohol or other substances? ☐ ☐
If yes, what type & how often?
_____
(Women only) Are you currently pregnant or nursing? ☐ ☐

HOBBIES:_____
_____

SPORTS:_____

FAMILY HISTORY

Is there a family history of any of the following?

	Relationship:
Blindness (disease/injury)	☐_____
Cataracts	☐_____
Corneal disease	☐_____
Diabetes	☐_____
Glaucoma	☐_____
Heart disease	☐_____
High blood pressure	☐_____
Lazy eye	☐_____
Macular degeneration	☐_____
Retinal conditions	☐_____

PATIENT'S EYE HISTORY

What is the major purpose of this visit?
_____
Date of last eye exam:_____
By whom?_____
Current glasses/contacts:_____
_____

Have you ever experienced, been diagnosed with or treated for any of the following?

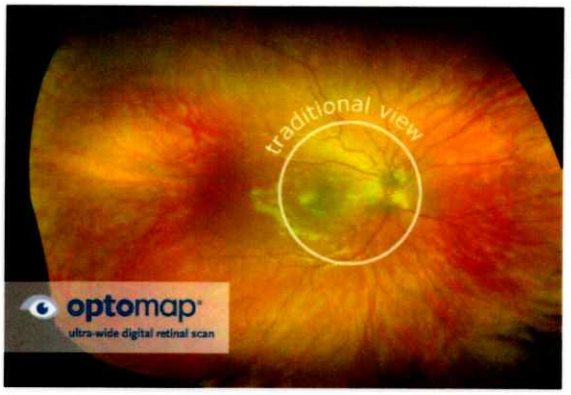
☐ Blurry vision
☐ Burning
☐ Cataracts
☐ Corneal abrasion
☐ Crossed eye/eye turn
☐ Double vision
☐ Dry eyes
☐ Eye infections
☐ Eye injury
☐ Floaters/flashes
☐ Glaucoma
☐ Headaches
☐ Iritis/uveitis
☐ Itching of the eyes
☐ Lazy eye/amblyopia
☐ Light sensitivity
☐ Macular degeneration
☐ Retinal detachment
☐ Tearing/watering of eyes
☐ Other eye conditions:_____
☐ Eye surgeries:_____

OCCUPATIONAL VISION NEEDS/REQUIREMENTS (safety glasses, computer use, etc.):_____
_____

Name:
Date:

Family Vision of Oregon

DIGITAL RETINAL EXAMINATION (Optomap)



We are proud to provide our patients with an advanced Digital Retinal Examination called Optomap, which scans the retina to rule out or screen for eye diseases. It also dramatically improves our ability to view your internal retinal health.

We are concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, retinal detachments, and diabetic retinopathy; all of which can lead to partial loss of vision or blindness. In addition, the effects of systemic diseases such as diabetes and high blood pressure can be detected during a retinal exam.

Our doctors recommend that you have a Digital Retinal Examination **once a year** so we can view and record your retina at up to 100 times its normal size. You can expect the following from this exam:

- An eye wellness screening photograph
- An in-depth view of the retinal surface
- The ability for the doctor to review the images with you
- A permanent record for your medical file, for serial comparison and diagnosis
- A fast and easy comfortable process

Insurance is designed to only cover a standard eye health exam. In many cases, it doesn't cover advanced procedures like the Digital Retinal Exam. Our doctors recommend this procedure for all our patients, and will perform this exam for an additional fee of **$39**.

☐ **YES, I WOULD** like to have my retinal health evaluated via the Digital Retinal Examination.
☐ **I DO NOT** wish to have the Digital Retinal Examination. I understand that I will still have a thorough eye examination via other modalities.

Patient's or Guardian's Signature

Family Vision of Oregon

Contact Lens Fitting and Evaluation Agreement

The contact lens fitting and evaluation monitors issues relevant to the fit and performance of contact lenses and ocular health. The fee for these services is not included in your comprehensive eye examination. The price depends on the type of contact lens your doctor decides is best for you. We will recommend the contact lenses that give you the best possible vision and fit your individual lifestyle.

Policies:

- Many insurance plans do not cover the full cost of contact lens fees. You will be responsible for any uncovered costs.
- You are responsible for scheduling and attending follow-up visits to finalize your prescription. If the contact lens evaluation process is not completed within 90 days, a new contact lens evaluation fee will be issued in order to finalize the prescription. Your prescription will not be released until it has been finalized by your doctor.
- If we determine that you are unable to be successfully fit during the initial fitting period of 90 days, you will be entitled to a refund on the cost of your contact lens materials. Professional fees for the contact lens fitting / evaluation are non-refundable.
- Contact lenses may be returned only within 30 days of the dispensing of the order. All boxes must be unopened and in unmarked packaging.
- Our doctors **strongly** recommend that all patients have up-to-date prescription spectacles in case of an eye infection that prevents contact lens wear, lost or torn contact lenses, and to periodically rest the eyes from contact lens wear.
- Contact lens prescriptions expire after one year.

Patient signature: _____ Date: _____