Clear Sight Optometry
TEMECULA EYE CARE

Patient Registration Form

Patient Name:_____ Today's Date: _____

Email:_____ Date of Birth: _____ Age: ___

Address:_____City:_____ Zip:_____

Phone Number:_____ ☐Cell ☐Home ☐Work Guardian (if applicable):_____

Occupation(s):_____ Employer:_____

Vision Insurance:_____ Subscriber Name:_____

Medical Insurance:_____ Subscriber Name:_____

How did you hear about us? _____ (e.g. Google, Location, Yelp, Insurance Referral, Friend)

Physician's (PCP) Name: _____ PCP City:_____

When was your last eye exam (appx.)?_____ @ _____

Do you currently wear glasses? ☐ Yes ☐ No Type: ☐ Full time ☐ Part time

Do you currently wear contact lenses? ☐ Yes ☐ No Brand/Power: _____

Interested in contacts? ☐ Yes ☐ No Interested in LASIK? ☐ Yes ☐ No

What is the main reason for your exam today? *Describe any eye problems or concerns you are having.*

_____

Your Eye/Medical History

Please check yes/no as applies to yourself.

	Yes	No
Blurry Vision	◯	◯
Eye Injury	◯	◯
Cataracts	◯	◯
Double Vision	◯	◯
Eye Surgery	◯	◯
Eye Infection	◯	◯
Dry Eye	◯	◯
Eye Allergies	◯	◯
Strabismus (Eye Turn)	◯	◯
Amblyopia (Lazy Eye)	◯	◯
Loss of Vision/Blindness	◯	◯
Glaucoma	◯	◯
Headaches/Migraines	◯	◯
Retinal Defects or Disease	◯	◯
Flashes of Lights	◯	◯
Floaters	◯	◯
Macular Degeneration	◯	◯
Uveitis/Iritis	◯	◯

	Yes	No
Allergies	◯	◯
Autoimmune	◯	◯
Arthritis	◯	◯
Blood/lymph	◯	◯
Bronchitis	◯	◯
Cancer	◯	◯
Cholesterol	◯	◯
Diabetes	◯	◯
Digestive	◯	◯
Ears/Nose/Throat	◯	◯
High Blood Pressure	◯	◯
Kidney	◯	◯
Muscle/Bone	◯	◯
Neurological	◯	◯
Psychological	◯	◯
Respiratory	◯	◯
Skin	◯	◯
Thyroid	◯	◯

	Yes	No
Do you drink alcohol?	◯	◯
If yes, how much?		
Do you use tobacco?	◯	◯
If yes, how much?		
Are you pregnant or nursing?	◯	◯

Other Medical Condition(s):

_____

_____

_____

_____

Allergies:

_____

Current Medications *(Or attach list)*:

_____

_____

_____

_____

Family Medical History

	Yes	No
Cancer	◯	◯
High Blood Pressure	◯	◯
Diabetes	◯	◯

	Yes	No
Thyroid Disease	◯	◯
Cataracts	◯	◯
Macular Degeneration	◯	◯

	Yes	No
Glaucoma	◯	◯
Crossed Eyes	◯	◯

Financial Policy

Welcome to our clinic and thank you for trusting your eye care needs to our office. So that we may better serve all our patients, the following details our Financial Policy.

Exam Fee Payment

Full payment is due at the time of service. We accept cash and major credit cards (VISA, Master Card, Discover, American Express). If you are using insurance benefits for your exam today, our staff will help you understand your insurance benefits and let you know what copays are due, if any.

Insurance

These are many different types of insurance payors. Most of the time, your Vision Plan (VSP, EyeMed, MES, etc.) is used for your comprehensive eye exam (think "annual physical for the eyes"). Depending on your situation however, it may be appropriate to bill your medical insurance benefits (Aetna, Blue Cross/Blue Shield, Medicare, etc.) for medical eye issues such as red eyes, emergency visits, and the like. Please present *both* types of insurance identification cards to our staff so that we may better direct your eye care. We will do our best to explain our recommendations to you. Some or all services and materials provided to you may not be covered as "reasonable and necessary" under the medical insurances. The balance may be your responsibility whether or not the insurance company pays.

Eyewear and Contact Lens Purchases

Full payment is due at the time of order for all eyewear and contact lenses.

Nonrefundable Materials

All prescription optical materials are customized and fabricated specifically for each individual patient. Fees for these materials are **Non-Refundable**, and once ordered, become the financial responsibility of the patient. We are not responsible for any materials not picked up after 90 days from delivery to our office.

Initial here (financial policy receipt): _____

Contact Lens Agreement

Any patient wishing to be fit in contact lenses must first undergo a Comprehensive Exam. If you are a good candidate for contact lenses, the Contact Lens Evaluation can proceed the same day or with a subsequent visit, up until 3 months after the Comprehensive Exam. The evaluation may include one or more follow-up appointments to monitor for adverse reactions. If a follow up is necessary, please return with your trial lenses.

Contact lenses are FDA regulated medical devices. An evaluation determines your unique lens power and size requirements as well as comfort and safety. For patients happy with their current contact lens brand/fit, the FDA still requires an evaluation at least annually for a valid prescription. This helps to prevent complications such as infection.

Contact Lens Evaluation Fees:

Your Contact Lens Evaluation Fee is based on the complexity of the contact lens fit. The evaluation fees range from $60-$111 based on your visual and eye health needs. These fees are due on the date of service. **First-time wearers will have an additional one-time $25 fee for training.** The Contact Lens Evaluation Fee covers follow-up care for up to three follow-up visits within 60 days after the initial contact lens fitting date. Any additional contact lens follow-up beyond the third visit or the first 60 days will have a $25 fee. We urge that you follow all instructions in the care of your vision and that you keep all scheduled appointments to maintain your eye health.

Once finalized, your contact lens prescription is valid for one year. Once expired, contact lens prescriptions will not be renewed without an annual exam to determine if changes have occurred.

By initialing below, I understand that a copy of the contact lens prescription will be provided at the end of the evaluation.

Return Policy:

- The Contact Lens Evaluation Fee is **Non-Refundable** reflecting services performed.
- Unopened AND unexpired AND unmarked boxes of contact lenses can be returned within 90 days of purchase for office credit that can be used for other eyewear or contact lens purchases for you and/or your friends and family.

Your Eye Health is Our Priority:

- Use and clean your lenses only as instructed and prescribed. Do not over wear your lenses or attempt to make them last longer than intended.
- If you have red, painful, or itchy eyes or if there is discharge coming from your eyes, remove your lenses and call our office immediately to make an appointment. Any changes to your vision and anything out of the ordinary should also be reported to us.

Contact Lens Patients Sign Agreement: _____

Notice of Privacy Practices, Pursuant to HIPAA Rule of 1996

Your privacy is important to us. As such, this notice serves as documentation on how we protect your privacy and disclose certain information, when required by law. You have the right to: get a copy of your medical record, correct your paper or electronic medical record, request confidential communication, ask us to limit the information we share, get a copy of this privacy notice, choose someone to act for you, and to file a complaint if you believe your privacy rights have been violated. Since your medical information is confidential, we keep your information guarded. However, we are allowed or required to share your information in order to comply with the law and other healthcare regulations. We may use and share your information to: treat you, run our organization, bill for your services, help with public health and safety issues, do research, comply with the law, respond to organ and tissue donation requests, work with a medical examiner of funeral director, address workers' compensation/law enforcement/other governmental requests, respond to lawsuits and legal actions. Please be aware that we are required to maintain the privacy and security of your protected health information. We will not use or share your information other than as described here unless you tell us we can in writing. Please inform the staff if you would like to receive a more detailed copy of this Notice of Privacy Practices.

I authorize Love Optometry, Inc., DBA "Clear Sight Optometry" to use my name on claims that relate to health insurance benefits and eye care services provided. I authorize payment of health/vision benefits to "Clear Sight Optometry" as a result of services provided. I understand that I am financially responsible, whether my insurance pays or not, for any charges incurred by me. I confirm receipt of the Notice of Privacy Practices.

Signature on File: **Date:**