Excel Optometry

Patient Form

General Information

Last, First, MI

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method ☐Cell phone ☐ Email ☐Text

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer

Marital Status ☐Married ☐Single ☐Divorced ☐Legally Separated ☐Widowed

Emergency Contact and Phone Number

How did you hear about us?

Insurance Information

Vision Insurance Plan Name

Primary Member

Primary Member Date of Birth

Primary Member Social Security Number

Medical Insurance Provider

Medical ID Number

Primary Member

Medical Policy #/Group #

Your Relationship to Primary Member

Eye History

Date of Last Eye Exam:

Currently Wear Glasses?

Currently Wear Contacts? (If yes, what brand?)

Reason for Today's Visit:

Have *YOU* experienced, or been treated for any of the following? (Circle all that apply.)

Cataracts	yes	no
Crossed Eye	yes	no
Glaucoma	yes	no
LASIK or PRK	yes	no
Lazy Eye	yes	no
Macular Degeneration	yes	no
Retinal Detachment	yes	no

Has anyone in your *FAMILY* experienced, or been treated for any of the following? (Circle all that apply.)

Cataracts	yes	no
Crossed Eye	yes	no
Glaucoma	yes	no
LASIK or PRK	yes	no
Lazy Eye	yes	no
Macular Degeneration	yes	no
Retinal Detachment	yes	no

Are you currently experiencing any, or have experienced, any of the following? (Check all that apply.)

- ☐ Blurry Vision Near or Distance
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Redness
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Sandy or Gritty Feeling

Medical History

Have you or a family member experienced, or been treated for any of the following? (Circle all that apply.)

AIDS/HIV	yes	no	family
Allergies	yes	no	family
Arthritis	yes	no	family
Asthma	yes	no	family
Blood/Lymph Disorder	yes	no	family
Cancer	yes	no	family
Diabetes	yes	no	family
Ears, Nose, Throat Conditions	yes	no	family
Gastrointestinal Conditions	yes	no	family
Heart Disease	yes	no	family
High Blood Pressure	yes	no	family
High Cholesterol	yes	no	family
Kidney Disease	yes	no	family
Lupus	yes	no	family
Neurological Conditions	yes	no	family
Psychiatric Disorder	yes	no	family
Seizures	yes	no	family
Skin Conditions	yes	no	family
Stroke	yes	no	family
Thyroid Dysfunction	yes	no	family

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

Informed Consent for Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the optometrist to get a better view of the inside of your eye.

Dilating allows the optometrist to get a better look at the back of the eye to check for any problems that can occur due to the following:

Systematic Diseases, such as Diabetes, High Blood Pressure, Cancer, etc. that can affect the eyes without obvious symptoms to the patient.

Physical Changes in your eyes, such as cataracts, glaucoma, retinal detachment, etc. that can affect your vision.

Dilating drops frequently blur vision for a length of time, which varies from person to person. They may also make bright lights bothersome. It is not possible for your optometrist to predict how much your vision will be affected. Driving may be difficult immediately after an examination, so it is best if you make arrangements not to drive yourself when you leave our office. If your child is dilated, he/she will have difficulty in completing school work and homework. In addition, he/she may not be able to participate in contact sports on the day of dilation.

- ☐ I have read and understood the above statement and recommendations. I choose to be dilated today.
- ☐ I do not wish to be dilated and I understand that certain pathologies may not be detected as a result.

Patient's Name:_____ Date:_____

Patient's/Legal Guardian Signature:_____ Date:_____

Excel Optometry Privacy Policy

NOTICE OF PRIVACY PRACTICES

Excel Optometry

27702 Crown Valley Pkwy. Suite A-3

Ladera Ranch, CA. 92694

(949) 429-3333

Patient Name:_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves, through a collection agency, or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance, personnel decisions; participation in managed care plans; defense legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask for your special written permission.

We will ask for special written permission in any situations that compromises your privacy.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the U.S. Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in a burial; or to organizations that handle organ tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.

- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation programs.
- Disclosures of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call at home, work, or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to the U.S Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notices in our office, have copies available in our office, and post it on our website.

PRIVACY POLICY ACKNOWLEDGMENT

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 services, and to conduct health care operations involving our office. The above Privacy Policy describes these uses and disclosures in detail.

Signature_____ Date_____