ITALI EYE CARE

PATIENT INFORMATION

Last Name: _____ First Name: _____ Sex: M / F

DOB: _____/_____/_____ SSN: _____ -_____ -_____ Email Address: _____

Cell Phone: _____ Secondary Phone: _____ Occupation: _____

Address: _____
(Street) (City) (State) (Zip Code)

Marital Status: _____ Primary Care Physician: _____ Last Medical Exam: _____/_____/_____

VISION INSURANCE

Insurance Name: _____ Insurance ID #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Relationship to Patient: _____

Group Name/Employer: _____ Policy Holder's DOB: _____/_____/_____

MEDICAL INSURANCE

Primary Insurance Name: _____ Insurance ID #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Relationship to Patient: _____

Group Name/Employer: _____ Policy Holder's DOB: _____/_____/_____

Do you have Secondary Medical Insurance? Yes / No Name of Secondary Insurance: _____

FINANCIAL RESPONSIBILITY: I certify that the above information is correct. I understand that payment is due in full at the time the services are rendered, including follow-up office visits related to my eye conditions and any non-covered services, co-payments, and deductibles. In the event that my vision/health plan determines that a service is not covered and denies payment for any reason, I understand that I am financially responsible for the complete charge. If my insurance company has not reimbursed Itali Eyecare, I may be billed for any services or products that I have received. If insurance benefits are being utilized for services, I hereby authorize direct payment of my vision and/or medical benefits to Itali Eyecare. I authorize the release of any medical or other information necessary to process my insurance claims. I understand that my signature recognizes my financial responsibilities and will be used only for those insurance plans that Jane Kim, O.D. at Itali Eyecare is a participating provider for.

CONSENT FOR TREATMENT: I hereby authorize Dr. Jane Kim to examine and administer diagnostic and medical procedures as deemed necessary for proper health care.

HIPAA ACKNOWLEDGEMENT: I hereby authorize Itali Eyecare to release any medical, incidental, or contact information that may be necessary to conduct treatment, to process insurance claims for payment of rendered services, to refer to another provider for further care, to send reminders for future appointments (via phone, text, paper mail, or email), and to process applications for other services (driver's license, rehabilitation, social security, disability, worker's compensation). I understand that my protected information can also be released to specific party or person(s) with written authorization. I have been offered a copy of Itali Eyecare's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

OPT-IN FOR E-MAIL AND CELL PHONE MESSAGING: By signing below, you agree to receive text messages and e-mails from Itali Eye Care. These messages include, but are not limited to, appointment reminders, promotions, and events. You may opt-out at any time by e-mailing italieyecare@gmail.com or through text.

SIGNATURE: _____ **Date:** _____/_____/_____

If Minor, Name and Relationship to Patient (if other than patient): _____

VISUAL HISTORY: Have ***you*** had any of these problems or currently experience any of these problems?

	Yes	No		Yes	No		Yes	No
Blurred Vision at Distance	☐	☐	Sandy or Gritty Eyes	☐	☐	Glare/Light Sensitivity	☐	☐
Blurred Vision at Near	☐	☐	Excess Watering	☐	☐	Flashes of Lights	☐	☐
Headaches	☐	☐	Dry Eyes	☐	☐	Floaters	☐	☐
Eyestrain	☐	☐	Eye Pain/Soreness	☐	☐	Double Vision	☐	☐
Burning	☐	☐	Frequent Styes	☐	☐	Loss of Vision	☐	☐
Itching	☐	☐	Red/Pink Eye(s)	☐	☐	Prosthetic Eye	☐	☐

OCULAR & MEDICAL HISTORY: Please indicate any ***personal*** or ***family*** history (parents, grandparents, siblings, children).

	Self	Family	None		Self	Family	None
Glaucoma	☐	☐	☐	Diabetes (Type 1 / 2)	☐	☐	☐
Cataracts	☐	☐	☐	High Blood Pressure	☐	☐	☐
Retinal Detachment	☐	☐	☐	High Cholesterol	☐	☐	☐
Macular Degeneration	☐	☐	☐	Thyroid Disease	☐	☐	☐
Crossed/Lazy Eye	☐	☐	☐	Cancer	☐	☐	☐
Blindness	☐	☐	☐	Stroke	☐	☐	☐
Uveitis / Iritis	☐	☐	☐	Arthritis	☐	☐	☐
Keratoconus	☐	☐	☐	Breathing Problems	☐	☐	☐

REVIEW OF SYSTEMS: Please indicate any conditions ***you*** currently have.

CONSTITUTIONAL	Yes	No
Fever	☐	☐
Fatigue	☐	☐
Weight Gain or Loss	☐	☐
Developmental Disability	☐	☐

ALLERGIC/IMMUNOLOGIC		
Seasonal Allergies	☐	☐
Graves Disease	☐	☐

NEUROLOGICAL		
Headaches / Migraines	☐	☐
Seizures / Epilepsy	☐	☐
Multiple Sclerosis	☐	☐
Cerebral Palsy	☐	☐
Brain Tumor	☐	☐

EAR/NOSE/THROAT/MOUTH		
Allergy / Hay Fever	☐	☐
Dermatitis (Eczema)	☐	☐
Dry Mouth / Throat	☐	☐
Sinusitis	☐	☐
Hearing Loss	☐	☐
Vertigo	☐	☐

RESPIRATORY		
Asthma	☐	☐
COPD	☐	☐
Shortness of Breath	☐	☐
Sleep Apnea	☐	☐

CARDIO/VASCULAR		
Heart Disease	☐	☐
Vascular Disease	☐	☐
Chest Pain	☐	☐
Stroke	☐	☐

GASTROINTESTINAL	Yes	No
Nausea / Vomiting	☐	☐
Changes in Bowel Movements	☐	☐

GENITOURINARY		
Kidney Disease	☐	☐
Prostate Disease	☐	☐
Sexually Transmitted Infections (Herpes, Chlamydia, Gonorrhea, Syphilis, HIV)	☐	☐

BONES/JOINTS/MUSCLES		
Ankylosing Spondylitis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐

SKIN		
Atopic Dermatitis	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐

BLOOD/LYMPH		
Anemia	☐	☐
Bruising or Bleeding Problems	☐	☐

PSYCHIATRIC		
ADD / ADHD	☐	☐
Depression	☐	☐
Anxiety	☐	☐

Other: _____

_____

[**Are you Pregnant or Nursing?** Yes / No]

List any allergies to medications or other substances: _____

List medications you take (prescription medications, over-the-counter medications, eye drops, home remedies)

_____

_____

Date of Last Eye Exam: _____/_____/_____

Age of Current Glasses: _____

Have you ever worn ***contact lenses***? Yes / No

If yes, what ***type/brand*** of contact lenses: _____

Have you had any eye or head ***injuries***? Yes / No

If yes, explain: _____

Have you had any eye ***surgeries***? Yes / No

If yes, explain: _____

Do you ***smoke***? Yes / No

How many years? _____

Do you ***drink***? Yes / No

If yes, how many drinks/week? _____

Do you use any recreational drugs? Yes / No

DILATION OF PUPILS

Health and ocular problems such as glaucoma, cataracts, retinal tears, diabetes, high blood pressure, and some tumors may be detected even before the onset of symptoms or loss of vision. Dr. Jane Kim highly recommends dilated eye exams. This procedure will temporarily result in blurred vision and sensitivity to light for about 3-5 hours. If needed, sunglasses will be provided. Many insurance plans include dilation as a covered benefit. Without insurance, the procedure is an additional **$20.00**. If you feel uncomfortable driving after this procedure, you may return at a later date with a driver. If you are using insurance, you must return within 30 days to have this procedure covered in full. Please check *one* of the following options:

_____ YES, I wish to be dilated today.

_____ NO, I do not wish to be dilated. I understand that I am assuming all risks associated with refusing this procedure and agree to hold Dr. Jane Kim harmless as a result of my actions.

Signature: _____ Date: _____/_____/_____

If Minor, Name and Relationship to Patient (if other than patient): _____

EYEWEAR (FRAMES, LENSES, SUNGLASSES) AGREEGMENT:

Please skip if you do **NOT** plan on purchasing with Itali Eyecare. Our eyeglass lenses are customized for the frame selected, as well as the individual's prescription. As such, half to full payment will be required to start the order, and any changes to eyeglass orders or returns must occur within 30 days of order. All orders are final when placed. No refunds are given on custom made prescription items. *If you are unhappy with your glasses for any reason, please bring them back to us so we may change them to meet your expectations*. This office will recheck any prescription at no cost within 60 days of the date on which the prescription was determined. If you were told at the time of the exam that your glasses will need to be altered for various medical reasons within the 60 day period, this recheck policy does NOT apply, and you may be charged a fee. You must be able to furnish the glasses that you had filled with a valid prescription if not filled through our office. After 60 days, a fee will be incurred for any recheck. Rechecks will not be performed after 6 months from original exam date, and a new eye exam will be necessary. If your eye exam was provided at Itali Eyecare, any remake of lenses as a result of doctor-ordered prescription changes will be done at no charge as a courtesy. If you provide a prescription from another office, any remake of lenses will be done at no charge *only one time* if lenses are of equal or lesser value and will not be subject to a refund of any differences in prices; Any remakes required beyond the one-time service will result in fees for the lenses and any treatments charged at 50% of our usual and customary fees. Frames and lenses purchased from our office have a *6-month manufacturer defect full-warranty, and it does NOT cover acts of abuse, loss, or theft*. If you used insurance to purchase your glasses, your warranty changes from our standard office warranty to your insurance company's warranty. By signing, you acknowledge that you understand the policies regarding the purchase of frames, lenses, and/or sunglasses at Itali Eyecare.

Signature: _____ Date: _____/_____/_____

If Minor, Name and Relationship to Patient (if other than patient): _____

CONTACT LENS AGREEMENT: Please skip if you do **NOT** wear contact lenses.

Contact lenses are a medical device that have the potential for serious complications if not used and fitted properly. For this reason, the Texas Board of Optometry requires an annual evaluation for a contact lens prescription (not part of the standard eye health exam), even if you have worn contact lenses in the past. The doctor will assess the health of the cornea (for ulcers, abnormal blood vessel growth, inflammation, etc.), the powers needed based on the patient's visual problems or changes, the stability of the lens on the eye, and the compatibility of the lens material and the eye. The estimated fee for these services range between **$40.00 to $80.00**. These fees will cover any contact lens related follow ups for a *60 day* period. The 60 day period does NOT include visits for medically related eye conditions that may or may not be related to contact lens wear (i.e. eye infections, ulcers, allergies, etc.). If you cannot complete the fitting procedure in the allotted time, then there will be an additional $30.00 charge per visit beyond the global time period. If you are wearing contact lenses for the first time, then there will be an additional $30.00 charge for training how to insert, remove, and take care of the contact lenses. All contact lens fitting fees must be paid in full at the time of examination, and it does NOT include any contact lens supplies/boxes. Half or full payment of contact lens supplies/boxes/vials must be made prior to ordering. Contact lens supplies/boxes may be exchanged or refunded within 30 days of purchase *only* if the product is unopened; otherwise, all contact lens supplies/boxes are non-refundable. By signing, you acknowledge that you understand the policies regarding the fitting of contact lenses and agree to the associated fees. You understand that these fees are an estimate and are subject to changes based on the doctors final assessment. You also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage, and if an infection is present you will need to be treated under your medical insurance prior to being fit with contact lenses.

Signature: _____ Date: _____/_____/_____

If Minor, Name and Relationship to Patient (if other than patient): _____