TODAY'S DATE___/___/___

PATIENT INFORMATION

LAST NAME _____ ***FIRST NAME*** _____ ***M*** ___ ***F*** ___ ***BIRTH DATE*** ___/___/___

ADDRESS _____ ***CITY*** _____ ***STATE*** _____ ***ZIP*** _____

HM PHONE(_____)_____ ***WK PHONE***(_____)_____ ***CELL PHONE***(_____)_____

EMPLOYER _____ ***ADDRESS*** _____ ***OCCUPATION*** _____

GUARDIAN/GUARANTOR'S NAME _____ ***HM PHONE***(_____)_____
(*If under 18 or different from pt. name*)

E-MAIL ADRESS _____ ***REFERERRED BY*** _____

INSURANCE INFORMATION

PLAN NAME _____ ***GROUP*** _____

INSURED NAME _____ ***RELATIONSHIP TO PT.*** _____ ***SELF*** _____ ***SPOUSE*** _____ ***CHILD***

INSURED ID/GROUP # _____ ***INSURED DOB*** ___/___/___ ***INSURED SS #*** _____-_____-_____

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAYS EXAM? _____

_____

_____

DATE OF LAST EYE EXAM___/___/___ **FROM DR.**_____ **OR PREVIOUS PT.**_____ **AGE OF PRESENT GLASSES**_____ **CONTACTS**_____

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENT, PARENTS, BROTHER OR SISTER) **HAVE ANY OF THESE CONDITIONS?**

	SELF	RELATIVE	NONE
DIABETES	○	○	○
HIGH BLOOD PRESSURE	○	○	○
THYROID PROBLEMS	○	○	○
HEART DISEASE	○	○	○
CANCER	○	○	○
ASTHMA	○	○	○

	SELF	RELATIVE	NONE
GLAUCOMA	○	○	○
CATARACTS	○	○	○
RETINAL DISEASE	○	○	○
EYE SURGERY	○	○	○
EYE INJURY	○	○	○
OTHER_____	○	○	○

	YES	NO
DO YOU SEE DOUBLE?	○	○
FREQUENT HEADACHES?	○	○
ARE YOU PREGNANT?	○	○
EYES BEEN DIALATED?	○	○

(IF YES TO DIALATED WHAT YEAR)_____

PRIMARY CARE DR._____

PLEASE EXPLAIN ANY POSITIVE FINDINGS: _____

_____

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)**? PLEASE LIST.** _____

_____

ARE YOU TAKING ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)**? PLEASE LIST.** _____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR OTHER? IF YES, PLEASE EXPLAIN. _____

(IF MORE SPACE IS NEEDED TO ANSWER ANY QUESTION PLEASE USE REVERSE SIDE) THANK YOU!

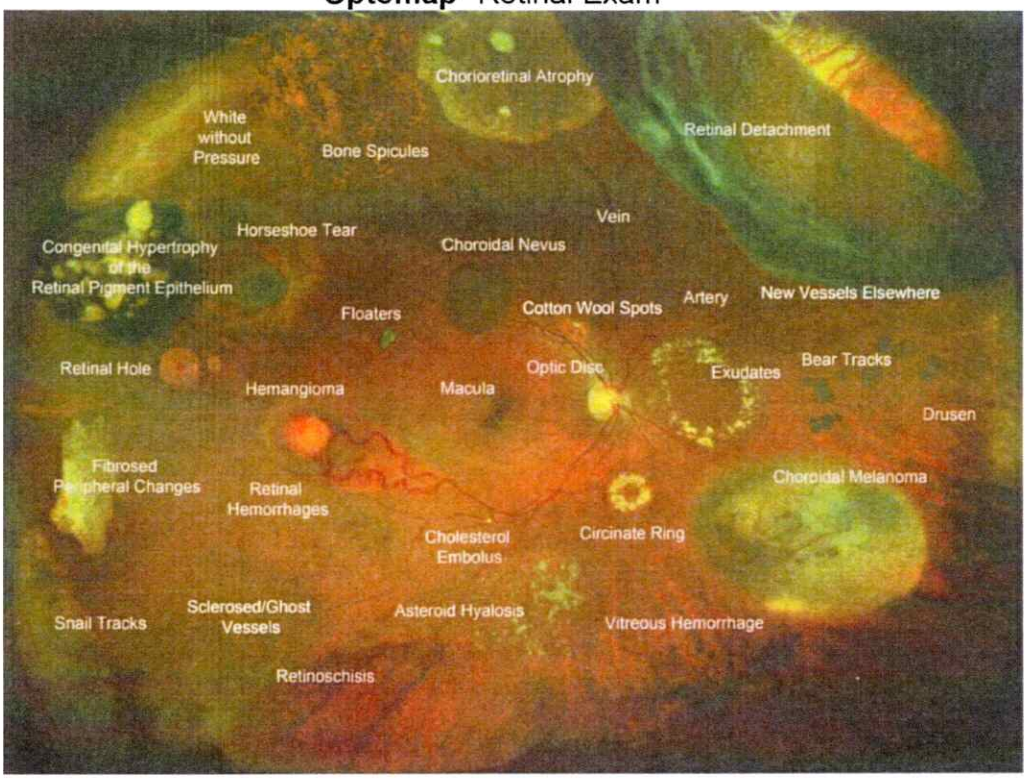
PT. SIGNATURE _____ *(GUARDIAN IF UNDER 18 OR GUARANTOR'S OF PT.)*

Insight
Family Vision Care, Inc.

At **Insight Family Vision Care, Inc**, we pride ourselves on providing our patients with the best possible standard of care. Because of this, we now perform the **optomap**® retinal exam with all of our patients. **This non-invasive procedure allows our doctors to see a much broader and more detailed view of the retina than is possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination.** Your Doctor strongly believes that the **optomap**® retinal exam is an essential part of your comprehensive eye exam and prescribes it for all patients once per year.

As part of your pre-test work up, we have captured **optomap**® images for review with your Doctor during your examination today. The $39 co-pay for this procedure may be a non-covered service unless being used to actively follow disease. Any questions you have about the **optomap**® retinal exam can be directed to your doctor when he reviews the images with you during your examination.

Optomap® Retinal Exam



_____Yes, I understand that my insurance benefits may not cover this advanced screening. Please sign and date below to acknowledge you have read the above statement and agree to the additional charges.

Sign_____Date_____

• +NOTICE OF HEALTH PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Acknowledgement Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to/for:

- Conduct,plan, and direct my treatment and follow-up among multiple healthcare providers (including pharmacies/pharmacists) who may be involved in my treatment directly and indirectly.
- Design, order, and fabricate optical materials prescribed by the doctor for my unique eye health and environmental needs (contact lenses, glasses, frames, lenses, telescopes, magnifiers, etc.) and contact you/your family when materials are completed.
- Obtain payment and or payment information for services, confirming insurance coverage, and billing or collection activities. An example of this would be: Sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice. Examples of this would include: posting of our daily schedule throughout the office, having a sign in sheet, calling to confirm appointments, leaving messages on your recorders regarding appointments, sending reminders/appointment cards in the mail with our practice name on them, using yours or a family members first and last name while serving you in our office, discuss with/allow immediate family members/guardians into the exam process to allow for a better understanding of treatment options when necessary.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document.

When you sign the consent acknowledgement, you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations as reviewed above and outlined in our Notice. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

As per HIPAA, we can decline to serve you if you elect not sign this consent acknowledgement.

SIGNATURE:_____ DATE:_____