9805 N. May Ave
The Village, OK 73120
(405) 749-2020

Appointment Date: ___/_____/_____

Patient Name:_____Date of Birth: _____
If patient is a minor list Parent/Guardian _____
Address:_____City:_____State:_____ Zip:_____
Phones: Home_____Cellular_____Business_____
Email: _____
Preferred method of contact: Call Text Email No Preference

INSURANCE INFORMATION (Please bring your insurance card and a valid I.D. to check-in)

Major Medical Insurance Company _____Policy #_____
Policy Holder's Name:_____ Date of Birth:_____

Does the patient have SoonerCare/Medicaid? ☐ Yes ☐ No ID#_____
Does the patient have VSP? ☐ Yes ☐ No SSN# of policy holder_____

PATIENT HISTORY

What is the main reason for today's visit? _____

Eye Health History

Date of last eye exam _____
Are you interested in LASIK? ☐ Yes ☐ No
Do you wear glasses? ☐ Yes ☐ No
Do you wear contacts? ☐ Yes ☐ No
Do you sleep in contacts? ☐ Yes ☐ No
Contact Lens Brand _____
Do you have any complaints or concerns with this brand? ☐ Yes ☐ No

Please check yes or no if you have had any of the following:

Bloodshot eyes	☐ Yes ☐ No	Floaters/Spots	☐ Yes ☐ No
Blurred Vision-Distance	☐ Yes ☐ No	Seeing Flashes	☐ Yes ☐ No
Blurred Vision-Near	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Poor Night Vision	☐ Yes ☐ No	Cataracts	☐ Yes ☐ No
Burning Eyes	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Itching Eyes	☐ Yes ☐ No	Light Sensitive	☐ Yes ☐ No
Color Vision Concerns	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	Temporary Vision Loss	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Eye Injury	☐ Yes ☐ No
Eye Infection	☐ Yes ☐ No	Eye Pain	☐ Yes ☐ No
Discharge from Eyes	☐ Yes ☐ No	Eye Lid Swelling	☐ Yes ☐ No
Twitching Eyelid	☐ Yes ☐ No	Eye Lid Pain	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	Difficulty wearing Contacts	☐ Yes ☐ No
Seeing Halos	☐ Yes ☐ No		

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Medical History (This information is kept strictly confidential. However, you may discuss this portion privately with the doctor if you prefer).

☐Yes, I would prefer to discuss this section with the doctor.

Primary Medical Doctor_____ City:_____

When was the last time you saw this doctor? _____

Do you use tobacco products? ☐ Yes ☐ No Type/Amount _____

Do you drink alcohol? ☐ Yes ☐ No Type/Amount _____

Do you use illegal drugs? ☐ Yes ☐ No Type/Amount _____

Review of Systems Please check "Yourself" or "Family Member" to indicate if you or a blood relative has ever had any of the following and indicate which family member has had the condition (Mom, Dad, Brother, Sister, etc…)

Check here if none of the following apply ☐ You ☐ Family

Arthritis	☐ You ☐ Family	High Blood Pressure	☐ You ☐ Family
Asthma	☐ You ☐ Family	Kidney Disease	☐ You ☐ Family
Allergies	☐ You ☐ Family	Lazy Eye	☐ You ☐ Family
Bleeding	☐ You ☐ Family	Lupus	☐ You ☐ Family
Blindness	☐ You ☐ Family	Macular Degeneration	☐ You ☐ Family
Cancer	☐ You ☐ Family	Migraines/Headaches	☐ You ☐ Family
Cataracts	☐ You ☐ Family	Retinal Disease	☐ You ☐ Family
Chemical Dependency	☐ You ☐ Family	Rheumatic Fever	☐ You ☐ Family
Diabetes	☐ You ☐ Family	Shingles	☐ You ☐ Family
Emphysema	☐ You ☐ Family	Skin Conditions	☐ You ☐ Family
Epilepsy	☐ You ☐ Family	Stroke	☐ You ☐ Family
Eye Surgery	☐ You ☐ Family	Thyroid Condition	☐ You ☐ Family
Glaucoma	☐ You ☐ Family	Tuberculosis	☐ You ☐ Family
Heart Disease	☐ You ☐ Family	Turned Eye	☐ You ☐ Family
Hepatitis	☐ You ☐ Family	High Cholesterol	☐ You ☐ Family

Other Conditions _____

Medications You are Currently Taking _____

_____

_____

You are allergic to the following

Medication Name	Reaction Type (Rash, Trouble Breathing, Vomiting)
_____	_____
_____	_____
_____	_____
_____	_____

How did you become aware of our practice? _____ Referred by _____

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ASSIGNMENT OF BENEFITS AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Full Spectrum Optometry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Full Spectrum Optometry to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party's Signature _____ Date _____
Relationship to Patient _____

Receipt of Notice of Privacy Policies and Consent Form
Full Spectrum Optometry

Patient Name _____ Date of Birth _____

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 our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy at www.fullspectrumoptometry.com if needed.

When you sign this consent document, you signify that 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 healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

You have a right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Full Spectrum Optometry.

Signature_____ Date _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Relationship to Patient _____ Print Name _____