FULL SPECTRUM OPTOMETRY

9805 N. May Ave.
The Village, OK 73120
P: (405) 749-2020
F: (405) 492-6446

Appointment Date:_____/_____/_____

Please bring your insurance card and a valid I.D. to check-in.

Patient First Name:_____ Last Name:_____ M.I. _____
DOB:_____ If minor list Parents/Guardian:_____
Address:_____ City:_____ State: _____
Zip:_____ SSN: _____
Phone: _____ ☐ Cell ☐ Home Email:_____
Preferred method of contact: ☐ Call ☐Text ☐ Email ☐ No Preference

INSURANCE INFORMATION

Major Medical Insurance Company:_____ ID #:_____
Policy Holder's Name:_____ Date of Birth:_____
Does the patient have SoonerCare/ Medicaid? ☐ Yes ☐ No Group #:_____
Does the patient have VSP? ☐ Yes ☐ No SSN# of policy holder:_____

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

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

PATIENT HISTORY

What is the main reason for today's visit?_____
Are you having any problems with your eyes? _____
Have you previously been diagnosed with any of the following:

Cataracts	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Keratoconus	☐ Yes ☐ No	Other	_____

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 _____

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REVIEW OF SYSTEMS

Please check "Yes or No" to indicate if you have ever had any of the following:

Allergies	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Apnea	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Migraine/Headaches	☐ Yes ☐ No
Autism	☐ Yes ☐ No	MS	☐ Yes ☐ No
Cancer:_____	☐ Yes ☐ No	Pregnant/Nursing	☐ Yes ☐ No
Cold Sores	☐ Yes ☐ No	Rosacea	☐ Yes ☐ No
Dev. Disorders	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Diabetes: Type 1 or 2	☐ Yes ☐ No	Smoker	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Thyroid Condition	☐ Yes ☐ No
GI Disorder	☐ Yes ☐ No	Tumor	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	Vascular Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Other:_____	
High Blood Pressure	☐ Yes ☐ No		

Please check if which blood relatives have ever had any of the following:

M=Mother, F=Father, B=Brother, S=Sister, Kids: Son/Daughter

Amblyopia (lazy eye)	☐M ☐F ☐B ☐S ☐K	High Blood Pressure	☐M ☐F ☐B ☐S ☐K
Blindness	☐M ☐F ☐B ☐S ☐K	Macular Degeneration	☐M ☐F ☐B ☐S ☐K
Cancer:_____	☐M ☐F ☐B ☐S ☐K	Retinal Detachment	☐M ☐F ☐B ☐S ☐K
Cataracts	☐M ☐F ☐B ☐S ☐K	Strabismus (Eye turn)	☐M ☐F ☐B ☐S ☐K
Diabetes: Type 1 or 2	☐M ☐F ☐B ☐S ☐K	Thyroid Condition	☐M ☐F ☐B ☐S ☐K
Glaucoma	☐M ☐F ☐B ☐S ☐K	Other:_____	☐M ☐F ☐B ☐S ☐K

Medications you are currently taking:

_____

_____

Are you allergic to any medications?

Medication name:	Reaction Type (Rash, Trouble Breathing, Vomiting)
_____	_____
_____	_____
_____	_____
_____	_____

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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:_____

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Dilation is an important part of a complete eye exam

To dilate the eyes, drops are used to relax the muscle, which controls the pupil size and allows the pupil to fully open. Side effects may include temporary blurred near vision, and in some cases distance vision, as well as sensitivity to light.

- For children under age 10, dilation is used to find the most accurate prescription by relaxing accommodation in addition to a full eye health evaluation. The side effects listed above may last up to 24 hours.
- For adults, dilation is used to complete a full eye health evaluation, with side effects usually lasting between four to six hours.

Patients may decline

Patients reserve the right to decline any test or diagnostic procedure recommended. If a patient declines, however, he or she assumes all of the risk for potentially not detecting, and thereby treating in a timely manner, any serious eye conditions.

Patients may reschedule

Patients that wish to postpone the dilated portion of the exam may do so without incurring an additional fee if the service is completed within 14 days/2 weeks. If the dilation is scheduled over 2 weeks from the initial appointment, there will be a fee for services rendered.

I Decline Dilation

By signing below, I agree to the following:

- I understand that I am assuming all risks associated with the failure to diagnose eye conditions, due to lack of information, which may have been provided by this test.
- Acting under my own will and judgment, I fully understand the circumstances associated with declining to have my eyes dilated.

Patient Name _____

Patient/Guardian Signature _____

Print Name_____**Date**

_____