9805 N. May Ave.
The Village, OK 73120

P: (405) 749-2020
F: (405) 492-6446

FULL SPECTRUM OPTOMETRY

Please submit all insurance cards and a valid I.D. at check-in. Date:_____/_____/_____

How did you become aware of our practice?
☐ Google ☐ Facebook ☐Advertisement ☐Drove By ☐Family/Friend _____
☐Other_____
☐ Yelp ☐Instagram ☐Postcard ☐Insurance ☐Previous Patient _____
_____

First Name:_____M.I._____
Last Name:_____
Birth Date:_____
SSN#: _____
Mobile Phone: _____
Home Phone: _____

Address:_____
City:_____State: _____Zip:_____
Email:_____

Do you give permission to text you? ☐ Yes ☐No

Emergency Contact _____ Phone_____

If patient is a minor
Mother's Name _____ Phone_____
Father's Name _____ Phone_____
Legal Guardian _____ Phone_____
(Documentation must be provided concerning legal guardianship)

IS THE MAIN REASON FOR YOUR VISIT VISION **OR** MEDICAL?

Option 1: These reasons may be covered under **VISION INSURANCE** and will be filed accordingly.

☐ I may need a glasses prescription
☐ I want new glasses prescription
☐ I need need a routine wellness exam
☐ I want a new contacts prescription
☐ I want to try contacts for the 1st time

Option 2: These conditions may be covered under **MEDICAL INSURANCE** and will be filed accordingly.

☐Red Eye ☐Dry Eye ☐Itchy Eyes ☐Vision Loss
☐Cataracts ☐Glaucoma ☐Eye Turn/Lazy Eye ☐Double Vision
☐Diabetes ☐Floaters ☐Macular Degeneration ☐Eye Pain
☐Other (please explain) _____

** If you have a medical condition and need a glasses/contact lens prescription, please be aware that your insurance may or may not cover that portion of the exam.
** While the doctor may diagnose a medical condition during a routine wellness exam, a second visit may be needed after the medical condition has been treated and resolved for an accurate glasses/contact lens prescription.

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Date _____ Patient's Full Name _____ Birth Date _____

REVIEW OF SYSTEMS

☐Yes ☐ No Allergies ☐ Yes ☐ No Apnea ☐ Yes ☐ No Arthritis ☐ Yes ☐No Asthma
☐ Yes ☐ No Autism ☐ Yes ☐ No Cold Sores/Shingles ☐ Yes ☐ No Dev. Disorders ☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy ☐ Yes ☐ No GI Disorder ☐ Yes ☐ No Hearing Loss ☐ Yes ☐No Heart Disease
☐ Yes ☐ No Migraine/Headaches ☐ Yes ☐ No Multiple Sclerosis ☐ Yes ☐ No Rosacea ☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Condition ☐ Yes ☐ No Vascular Disease ☐ Yes ☐ No Other:_____
☐ Yes ☐ No Cancer: Type _____ Diagnosis Date_____ Remission: Yes / No
☐ Yes ☐ No Diabetes: Type _____ Diagnosis Date_____ A1C&Date_____ Todays Glucose _____
☐ Yes ☐ No Are you currently nursing?
☐ Yes ☐ No Are you currently pregnant? Term _____ Due Date _____

Do you use tobacco products?
☐Never Smoked ☐Former Smoker Packs/day _____
☐Current Smoker Packs/day____ ☐Smokeless tobacco Amount/day_____

Do you drink alcohol?
☐ Yes ☐ No If yes, # of drinks per week: _____

Primary Care Physician _____**Location** _____ **Last Visit**_____

History of EYE Surgeries /Date_____

Current Medications **Prescribing Doctor / Location**

_____ _____/_____
_____ _____/_____
_____ _____/_____

IF YOU HAVE A MEDICATION LIST WE CAN COPY FOR YOU.

ALLERGIES (Please list any medications, food or environmental allergies and the **associated allergic response**)

_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____
_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____
_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____

Please check the **IMMEDIATE FAMILY MEMBER** that has any of the following:

Eye Conditions

Amblyopia (lazy eye)	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Strabismus (Eye turn)	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Blindness	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Macular Degeneration	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Retinal Detachment	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Glaucoma	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Cataracts _____	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Other Eye Condition:	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter

Health Conditions

Diabetes Type 1/2	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Heart Disease	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
High Blood Pressure	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Thyroid Condition	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Hypothyroid Condition	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Cancer _____	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter
Other Medical_____	☐ No ☐Unknown ☐Adopted ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter

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IMPORTANT INSURANCE INFORMATION

Patient Name: _____ **Date:** _____
Patient Name: _____ **Date:** _____
Patient Name: _____ **Date:** _____
Patient Name: _____ **Date:** _____

You may complete 1 form and list all family members above.

PRIMARY MAJOR MEDICAL INSURANCE		**VISION INSURANCE**
Company		Company
Primary Holder		Primary Holder
Primary Holder Birth Date		Primary Holder Birth Date
Primary Holder SSN#		Primary Holder SSN#
Member ID#		Member ID#
Group#		
SECONDARY MAJOR MEDICAL INSURANCE		We file most insurances as a courtesy to our patients. Verifying eligibility of insurance is not a guarantee of insurance payment. You are responsible for knowing your insurance coverage. In the event the insurance is not active at the time of service, billing goes towards your deductible, claim is denied or you are unable to provide active insurance information before/on the date of your exam, you are responsible for the balance.
Company		
Primary Holder		
Primary Holder Birth Date		
Primary Holder SSN#		
Member ID#		
Group#		

ASSIGNMENT OF BENEFITS AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage with those listed above 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: _____

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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 to 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.

_____ Initial if you consent to text and/or email communications for appointment verification, appointment reminders, glasses order completion notification, contact lens order notification. At any time you wish to discontinue this line of communication, please notify our office.

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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