UPTOWN EYES
EYEWEAR GALLERY
100 E. Joyce Blvd. 104
Fayetteville, AR 72703
P: 479.966.4232
Uptowneyesnwa.com

Welcome to our Office!

PATIENT INFORMATION

DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____

DAYTIME PHONE: (_____)_____

CELL PHONE: (_____)_____

EMAIL: _____

How would you like our office to communicate with you?

____ Email _____ Text _____ Phone

DATE of BIRTH: _____ AGE: _____

PATIENT'S SSN: _____

SEX: _____ MALE _____ FEMALE

EMPLOYER OR SCHOOL: _____

OCCUPATION OR GRADE: _____

SPOUSE OR PARENT NAME: _____

If over the age of 18 years, may we discuss your account with the person named above? _____ Yes _____ No

PCP Name: _____

Pharmacy: _____

Preferred Language: _____

Race:

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Hawaiian / Other Pacific Islander
- ○ White
- ○ Black or African American
- ○ Other

Ethnicity: ○ Hispanic/Latino ○ Non-Hispanic/Latino

REFERRAL INFORMATION

How did you hear about us?

- ○ Friend or Relative: Who? _____
- ○ Ad: Which one? _____
- ○ Another Doctor _____
- ○ Sign/Building _____
- ○ Social Media: _____ FB _____ Insta _____ Google+
- ○ Website
- ○ Insurance Listing _____
- ○ Event: _____
- ○ Other: _____

PATIENT MEDICAL HISTORY

CURRENT MEDICATIONS (Rx and OTC):

_____

_____

_____

ALLERGIES TO MEDICATIONS? ○ YES ○ NO

Please List:

_____

_____

INSURANCE / PREFERRED PAYMENT

VISION PLAN: _____

SUBSCRIBER NAME: _____

SUBSCRIBER SSN: _____

SUBSCRIBER DOB: _____

PRIMARY MEDICAL INS: _____

SUBSCRIBER NAME: _____

SUBSCRIBER SSN: _____

SUBSCRIBER DOB: _____

PATIENT EYE HISTORY

DATE OF LAST EYE EXAM: _____

PREVIOUS DOCTOR/CLINIC: _____

Do you currently wear contact lenses? _____ Yes _____ No

If so, What kind? _____

How often do you replace your lenses? _____

Do you sleep in your lenses? _____ Yes _____ No

SOCIAL HISTORY

Please Circle:

ALCOHOL? None / Rarely / Monthly / Weekly / Daily

TOBACCO? No / Smokeless / _____ packs per day/week

- ○ Never Smoker
- ○ Former Smoker
- ○ Occasional Smoker
- ○ Current Smoker

FAMILY HISTORY

	Self	Family	Relationship to Patient:
Cancer	○	○	_____
Diabetes	○	○	_____
High Blood Pressure	○	○	_____
Heart Disease	○	○	_____
Kidney Disease	○	○	_____
Lupus	○	○	_____
Thyroid Disease	○	○	_____
Arthritis	○	○	_____
Blindness	○	○	_____
Cataracts	○	○	_____
Macular Degeneration	○	○	_____
Glaucoma	○	○	_____
Lazy Eye	○	○	_____
Double Vision	○	○	_____
Corneal Problems	○	○	_____
Dry Eye	○	○	_____
Floaters/Spots in vision	○	○	_____
Retinal Problems	○	○	_____
Other	○	○	_____

HOBBIES/INTERESTS

Please list your hobbies/interests:

_____

_____

UPTOWN EYES
EYEWEAR GALLERY

Consents and Policies

Name: _____ Date: _____

Consent for Dilation (Please read and Initial)

Dilation involves instilling eye drops to enlarge the pupils to allow a more thorough assessment of the retina. The most common side effects are increased light sensitivity and temporary reduction in near focusing, usually lasting 2-3 hours. In some cases, distance vision may be affected as well. There is no additional charge for this service. It is hightly recommended to have your eyes dilated if you are: 1) New to our office; 2) Diabetic; 3) Over 50 years old; 4) Highly near-sighted; 5) Having symptoms of flashes/floaters.

_____ **Yes**, I understand the common side effects of dilation and consent to having my eyes dilated.
_____ **No**, I decline dilation. I have been fully informed of and understand the reasons the dilation is recommended.

Consent for Retinal Imaging/Photos (Please read and Initial)

Retinal photos assist us in the early detection of glaucoma, macular degeneration, diabetic changes and other retinal disorders. This permanent record is very valuable in assessing the current health of your eyes and will serve as a baseline from which to compare, as we follow your ocular health. The screening fee is not covered by insurance and is $39.00.

_____ **Yes**, I consent to Retinal Imaging and agree to pay the $39.00 for the screening.
_____ **No**, I do not consent to Retinal Imaging and I understand I will be dilated today or scheduled at a later date.

Policies (Please read and initial)

_____ **Contact Lens Evaluation Fee Policy:** Your contact lens evaluation includes 3 months of follow-up care. It is your responsibility to keep your follow-up appointments and correspondence for follow-ups so the doctor can finalize your contact lens prescription. Failing to do so in the 3 month period will result in another contact lens evaluation fee. If it is more than 6 months, you will need a new exam.

_____ **Contact Lens Return Policy:** If boxes are unopened, unmarked, contact lenses may be exchanged within 60 days. Due to the customized nature of contact lenses, no refunds will be made after the final prescription is determined.

_____ **Spectacle Return Policy:** We strongly believe in 100% satisfaction. An office visit to recheck the prescription will be provided and new lenses will be made at no charge within 30 days of dispensing. Due to the customized nature of your lenses, no refunds are issued for prescription lenses. In the event of a cancelled order or returned frame, a 10% frame restocking fee will be charged.

Privacy Policy (Please read and sign below)

HIPAA: Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose protected health information about you. You have the right to review our NPP before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one or find the updated version on our website. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Acknowldedgement of Receipt of Notice of Privacy: I have been offered and/or received a copy of Notice of Privacy Practices as required by HIPAA Privacy Regulations, effective April 14, 2003.

Signature: _____ Date: _____

Insurance Authorization/Payment Guarantee: In order to control costs, we kindly ask for the patient's portion to be paid at the time services are rendered. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Uptown Eyes, PLLC. I understand that all benefits quoted to me are NOT a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature: _____ Date: _____