Patient Registration Information

Optica Optometry, 1121 El Camino Real, South San Francisco, CA 94080
(650) 866 - 4641 ; Opticaoptometry@gmail.com

Date: ____________________

Patient Information

Title	Name			
Mrs. Mr. Ms. Other______ Pronouns___________	Last	First	Nickname	MI
Mailing Address	Street	City	State	Zip Code
Phone Number	Cellular ( )	Other ______________ ( )	Other ____________ ( )	Email Address ______________________________
Birth Date / /	**Birth Sex** ☐ Female ☐ Male	**Patient SSN** / /	**Occupation** ________________	**Referred By** ____________________________

Vision Insurance Information

Member Name *(or self)* ___________________________ Member SSN (Last 4) ___________________ DOB ____________

Name of Insurance Co. ___________________________ Relationship to patient _________________

Member ID *(if available)* ____________________________ Group ID *(if available)* ______________________________

Medical Insurance Information

☐ Aetna ☐ Blue Cross/Blue Shield

☐ Cigna ☐ Kaiser ☐ United Health Care

☐ Medicare Other ____________________

Please provide staff with your medical ins. card

Emergency Contact

Name _____________________________

Relationship ______________________

Phone ____________________________

General Health History

Reason for Visit / Any Ocular Symptoms?

____

____

Do you wear glasses? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Hours/day ______________

List all medications you are taking, including eye drops

____

____

____

____

____

List your allergies to medications and other substances

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____

____

____

Check appropriate boxes to indicate if you and/or your family have any of these conditions:

Condition	Self	Family	Condition	Self	Family
AIDS/HIV	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐			
Blindness	☐	☐	Lazy Eye	☐	☐
Cancer	☐	☐	Lupus	☐	☐
Cataracts	☐	☐	Migraine	☐	☐
Diabetes	☐	☐	Headaches	☐	☐
Eye Surgery	☐	☐	Retinal Disease	☐	☐
Glaucoma	☐	☐	Stroke	☐	☐
Hay Fever	☐	☐	Thyroid	☐	☐
Heart Condition	☐	☐	Other	☐	☐
Hepatitis_____	☐	☐	_________		

Pregnant	☐ Yes ☐ No	
Alcohol	☐ Yes ☐ No	
Rec. Drug	☐ Yes ☐ No	
Tobacco use	☐ Yes ☐ No	Type/Frequency ______________________________

By signing, you acknowledge the validity of information you have provided above is accurate and true.

Signature *(Parent/Guardian if patient under 18yo)* ____

Office Policies

● Contact lenses are considered medical devices and thus require a contact lens exam every year you wish to receive a contact lens prescription. This is separate from the comprehensive eye exam and is subject to the copay stated by your insurance or to a contact lens exam fee. If you have questions about your contact lens exam coverage, please ask our staff.
● All sales on glasses are final. Because prescription lenses are custom-made per individual, returns may be denied. Any exception must be authorized by the office manager.
● Any Rx verifications on glasses or contacts made with an Rx from Optica Optometry must be done within 90 days of your eye exam. Rx verifications beyond this time are subject to an additional fee due to possible changes in your vision.

  ● Additionally, Rx verification on glasses made elsewhere must be re-checked there **first**. If we find that the necessary change is an error made by them, you may be subject to a Rx verification fee.

By signing, you acknowledge that have read and understand our office policies.

Signature (Parent/Guardian if patient under 18yo) ____

Receipt of Notice of Privacy Policies and Consent Form

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** 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.
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 here at the office.

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 read through our **Notice of Privacy Practices**.

You have the 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.

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 the optometric clinic of Optica 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 _____________________________________ Print Name ____