Patient Information — **Fernando Chen, O.D., Inc.**

Name: _____ Age: _____ Birth Date: _____ □ Male □ Female

Occupation: _____ Parent's Name (if patient is a child): _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ E-mail: _____

Do you have vision insurance? □ Yes □ No (**If yes, please present your insurance card to the reception desk for verification and eligibility**)

Person to contact in case of an emergency _____ Relationship: _____ Phone: _____

Whom may we thank for referring you? _____

ROS / Personal & Family Medical, Social History

Family Health History
(Check each if someone in your family has had)

- □ Allergies
- □ Arthritis
- □ Asthma
- □ Blackouts
- □ Cancer
- □ Diabetes
- □ Drug Sensitivity
- □ Elevated Cholesterol
- □ Hay Fever
- □ Heart Condition
- □ High Blood Pressure
- □ Migraine Headaches
- □ Skin Condition
- □ Thyroid Condition
- □ Tuberculosis

Patient's Health History List Prescription & Non-Prescription Medications:
(Check each you have had)

- □ Allergies …….
- □ Arthritis…….
- □ Asthma…….
- □ Blackouts…….
- □ Cancer ..…….
- □ Diabetes ……..…..
- □ Drug Sensitivity…….
- □ Elevated Cholesterol…….
- □ Hay Fever……..
- □ Heart Condition…….
- □ High Blood Pressure…….
- □ Migraine Headaches…….
- □ Skin Condition……..
- □ Thyroid Condition…….
- □ Tuberculosis…….

Explanation of health history, where necessary: _____

_____

*** Medications I am ALLERGIC / sensitive to**: ☐ None Known ☐ Yes, to: _____

Family Doctor: _____ Phone: _____

Females only: Are you pregnant or nursing? □ Yes □ No

Personal & Family Eye History

Patient's Visual Symptoms
(Check if you currently have)

- □ Blurred distance vision
- □ Blurred near vision
- □ Burning eyes
- □ Discomfort at distance visual tasks
- □ Double vision
- □ Dry Eyes
- □ Eye Strain
- □ Gritty feeling (feels like sand)
- □ Headaches related to eyes
- □ Itching eyes
- □ Light sensitivity
- □ Red eyes
- □ See flashing lights
- □ See floaters or spots
- □ Temporary loss of vision
- □ Twitching eyelids
- □ Variable vision
- □ Watery Eyes

Do **you** and/or a **family member** have, or ever had any of the following?

□ Diabetic Retinopathy	Self	Family Member: _____
□ Retinal Detachment	Self	Family Member: _____
□ Macular Degeneration	Self	Family Member: _____
□ Lazy Eye (Amblyopia)	Self	Family Member: _____
□ Strabismus (Eye Turn)	Self	Family Member: _____
□ Cataracts	Self	Family Member: _____
□ Glaucoma	Self	Family Member: _____
□ Color Blindness	Self	Family Member: _____
□ Blindness	Self	Family Member: _____
□ Iritis, Uveitis	Self	Family Member: _____
□ Optic Neuritis	Self	Family Member: _____

Have you had any serious eye disease, eye injury, or eye surgery? □ Yes □ No

If yes, please describe: _____

When was your last visit to your eye doctor? _____

What is your previous eye doctor's name? _____

Do you currently see an eye specialist (ophthalmologist)? □ Yes □ No

Do you currently wear contact lenses? □ Yes □ No

The information that I have provided on this form is complete, true, and accurate to the best of my knowledge.

X _____ **Date:** _____

Signature of Patient, Guardian, or Personal Representative

Acknowledgement of Receipt of Privacy Policies

I acknowledge that I have received a copy of the Notice of Privacy Practices for Fernando Chen, O.D., Inc.

X _____ **Date:** _____

Signature of Patient, Guardian, or Personal Representative

_____ _____

Please print name of Patient, Guardian, or Personal Representative — Relationship to Patient

You can request a copy of the Notice of Privacy Practices for Fernando Chen, O.D., Inc. at any time in person or by phone. You can also obtain a copy online at www.chenoptometry.com

Dilated Fundus Examination Informed Consent

Dilating the pupils with eye drops is necessary to obtain a better view inside your eyes in order to ensure optimal eye health. Many eye diseases can be diagnosed early through a dilation which otherwise may not be detected.

The doctor recommends that your eyes should be dilated today, especially if….

1. You are experiencing changes in your vision.
2. You or a family member has a history of high blood pressure, diabetes, cataracts, glaucoma or other eye disease.
3. You have headaches which you think may be related to your eyes.
4. You are a first time patient to this office.
5. You have not had your eyes dilated within the last 2 years.
6. You have unusual visual symptoms such as “floater” or “flashes of light”
7. You have a strong prescription for glasses.

In most cases, having your eyes dilated will not affect your distance vision, but you may experience some difficulty reading and mild sensitivity to light for **three to five hours**. You may elect to schedule the dilation on another date and bring someone to drive you home.

The cost of having your eyes dilated is $20. If you have any questions regarding the dilation, please ask the optometrist.

Please Check Only One:

□ I understand the importance of a dilated fundus exam and would like my eyes dilated.

□ I understand the above and decline a dilated fundus exam at this time. I understand the potential for partial or total loss of vision may exist, and without a dilated exam may go undetected. I understand that I am releasing Fernando Chen, O.D., Inc. from any liability by not having the dilated fundus exam.

X _____ **Date:** _____

Signature of Patient, Guardian, or Personal Representative

For all Contact Lens Wearers

In consideration for Dr. Chen’s agreement to release your contact lens prescription, you agree to the following:

I have been informed of the requirements to schedule and attend follow-up appointments with my optometrist and to comply with the wearing schedule and cleaning method my optometrist has set for me. I understand that I am responsible for injuries, which may occur, as a result of my failure to attend follow-up appointments or to comply with the wearing and cleaning schedule. I agree to indemnify, hold harmless and waive and release from any and all claims, legal action and attorney fee, which may arise as a result of my failure to comply with the instructions set forth by my optometrist, or agents thereof.

I acknowledge that I cannot hold Dr. Chen or his designated associate optometrists responsible for injuries I sustain because I have not provided Dr. Chen or his associate optometrists with the opportunity to monitor my progress. In the event that Dr. Chen, his agent, or an optometrist employed by Dr. Chen, releases a contact lens prescription, which is filled by a dispenser other than the prescribing optometrist, I agree to indemnify, hold harmless and to waive and release from any and all claims, legal action and attorney fees, which may arise as a result of the negligence or willful act of the non-prescribing dispenser, against the prescribing optometrist, or agents thereof.

I understand that the doctor may recommend a follow-up visit to finalize the fit of my contact lenses. There is no charge for this visit if within 60 days of the initial visit. After 60 days but not more than 6 months from the initial visit, there is an office visit fee of $40. After 6 months, a complete contact lens exam will be charged. Only one trial pair of contact lenses will be permitted per patient if Rx applicable.

All first time contact lens patients will be charged a mandatory $20 training appointment.
Also, I understand that my contact lens prescription will expire in 1 year.

I understand that it is **my responsibility** to schedule and keep follow-up visits and annual exam appointments. **I have read and understood the above.**

X _____ **Date:** _____

Signature of Patient, Guardian, or Personal Representative