Office Use Only:
Retinal Photo ☐

PATIENT INFORMATION (Please Print)__ Today's Date:_____

Title (Please circle): Dr. Mr. Mrs. Miss. Ms. Child**

Patient's Name:_____ Age: ____ Birth Date:_____
(Last) (First) (Middle) (MM/DD/YY)

If Minor, Parent's Name:_____
(Last) (First) (Middle)

Social Security # _____ Sex (Please circle) M or F

Address: _____
(Number & Street, Apt #) City/State Zip

Phone: Home (____)_____ Day (____)_____
Cell (____)_____ E-Mail _____

Student Status: ☐ Full-Time ☐ Part-Time ☐ N/A

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Employer: _____ How did you hear about us: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Active Military ☐ N/A

INSURANCE INFORMATION

Insurance Provider:_____ Member ID# _____
Policy # _____ Group ID # _____

Is the patient the primary insured? ☐ No ☐ Yes
(If no, please complete the Primary Insured Information section below.)

PRIMARY INSURED INFORMATION

Primary Insured Name: _____
(Last) (First) (Middle)

Address: _____
(Number & Street, Apt #) City/State Zip

Relationship to Patient: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorce ☐ Widowed

Student Status: ☐ Full-Time ☐ Part-Time ☐ N/A Social Security # _____

Birth Date _____ Sex (Please circle) M or F

Home Phone: _____Work Phone: _____

Employer: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Active Military ☐ N/A

** Children ages 15 and younger must be accompanied by a parent/guardian or an adult with consent for examination. Children 16 and up to age 18 must have written or verbal consent from parent/guardian.

All insurance patients: The procedures performed in this office are medical in nature. Professional fees will be submitted to your vision insurance. By signing below, you authorize payment of insurance benefits to Lili Lam, OD & Associates PA. You will be financially responsible for any balance not paid by insurance. Professional fees are non-refundable.

Parent/Guardian Signature _____ Date _____

PERSONAL EYE HISTORY

Reason for today's visit: _____

Do you wear glasses? ☐ No ☐ Yes Contact lenses? ☐ No ☐ Yes

Have you worn contact lenses in the past? ☐ No ☐ Yes

Are you interested in trying contact lenses? ☐ No ☐ Yes

Contact lens wearer, what brand of contact lenses do you wear:_____

How often do you replace your contacts? _____

Have you had an eye exam in the past 2 years? ☐ No ☐ Yes Place of last exam _____

Please list if you have ever had any eye injuries, diseases or surgeries (eg. lazy eye, glaucoma):

_____

Do you experience any of the following:

Blurry vision	☐ No ☐ Yes	Double vision	☐ No ☐ Yes
Red Eyes	☐ No ☐ Yes	Watery eyes	☐ No ☐ Yes
Itchy Eyes	☐ No ☐ Yes	Dry Eyes	☐ No ☐ Yes
Flashing lights	☐ No ☐ Yes	Floaters	☐ No ☐ Yes

Other_____

PERSONAL MEDICAL HISTORY

Do you have any allergies to medication? ☐ No ☐ Yes If yes, please list:

_____

Please list all medications you are currently taking (including over the counter)

_____

Please list any major surgeries you have had:

_____

Do you or have you ever experienced any problems in the following areas?

Neurological (eg. headaches, migraines, seizures)	☐ No ☐ Yes	Describe: _____
Ear/Nose/Throat (eg. allergies, sinus)	☐ No ☐ Yes	Describe: _____
Endocrine (eg. diabetes, thyroid)	☐ No ☐ Yes	Describe: _____
Respiratory (eg. asthma, bronchitis)	☐ No ☐ Yes	Describe: _____
Vascular (eg. high blood pressure, high cholesterol)	☐ No ☐ Yes	Describe: _____

Other: _____

Are you pregnant or nursing? ☐ No ☐ Yes

FAMILY MEDICAL & EYE HISTORY

Has anyone in the patient's family (blood relative) had any of the following?

Cornea Disease	☐ No ☐ Yes	Crossed Eyes	☐ No ☐ Yes
Glaucoma	☐ No ☐ Yes	Lazy Eye	☐ No ☐ Yes
Macular Degeneration	☐ No ☐ Yes	Retina Disease	☐ No ☐ Yes
Heart Disease	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes	Cancer	☐ No ☐ Yes

Other_____

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INFORMED CONSENT FOR DILATION AND RETINAL PHOTOS

Florida laws require optometrists to dilate the eyes of all new patients and thereafter as medically indicated. Dilation allows the doctor to better examine your eyes for disease. It does not affect your eyeglass or contact lens prescription. Side effects may include blurred vision and light sensitivity for 2 to 4 hours. It is NOT recommended that you drive if your vision is blurred.

Do you consent to the dilation of your eyes today? ☐ No ☐ Yes

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I received a copy of the NOTICE OF PRIVACY PRACTICES at this office location. I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the NOTICE OF PRIVACY PRACTICES.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:
   Office of Dr. Lili Lam, OD & Associates PA
2. Persons/organizations authorized to receive the information: Target Optical
3. Specific description of information that may be used/disclosed: **my name, address, telephone number, email address and next appointment date(s) and time(s).**
4. As part of our recall program, the information will be used/disclosed for the following purposes: (a) For the purpose of providing coupons and service and product information either from this office or directly from Target Optical; and (b) to compare mailing lists with Target Optical to help avoid duplicate mailings.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment: receive payment or eligibility for benefits unless allowed by law.
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that: (a) action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy.
8. This authorization expires for seven years from the date of my signature.

Do you authorize the use or disclosure of individually identifiable health information as described above?

☐ No ☐ Yes

Signature_____ Date _____

(If minor child, PARENT MUST SIGN.)

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Print name _____ Relationship to Patient _____

Source of Authority _____

Signature _____ Date _____

Contact Lens Agreement

At **Lili Lam, OD & Associates PA**, we carry the latest in contact lens technology and specialize in the difficult-to-fit patients. This includes astigmatism-correcting lenses (toric), multifocal lenses, monovision fits and regular hard contact lenses (RGPs). We are dedicated to your health and an enjoyable, comfortable contact lens experience.

A **Contact Lens Fit Evaluation** fee is necessary for all contact lens prescriptions and is in addition to the comprehensive eye examination fee. This evaluation will include precise measurements, analysis of your vision needs and recommendations specifically tailored for you. It may also include the use of diagnostic lenses if necessary by our doctors to ensure the proper fit of the lenses and good ocular health.

The Contact Lens Evaluation fee will range in price depending on the complexity of the contact lenses worn:

- **Standard** Contact Lens Evaluation (soft spherical).....$50
- **Toric** Contact Lens Evaluation (for astigmatism).....$80
- **Standard Monovision** Contact Lens Evaluation……...$80
- **Multifocal/Modified Monovision** Contact Lens Evaluation……....$90
- **Standard Hard Contact** Lens Evaluation (spherical RGP).....$120

This fee will cover the initial evaluation and all contact lens related follow-up visits for a period of 3 months. If necessary, it will also include the cost of any additional contact lens training sessions needed for those individuals needing contact lens instruction for insertion, removal and lens care. Follow up after 3 months may incur new contact lens fitting and/or exam charges.

* Contact Lens prescriptions are valid for **1 year**

YOUR NEXT EYE EXAM APPOINTMENT REMINDER

You will be reminded for your next eye exam. Please check the primary communication preference or check NO if you would like to opt-out of this reminder:

(Please check one)
E-mail [ ]
Text [ ]
Telephone Call [ ]
NO - Do not remind me of my next eye exam [ ]

Patient Initial_____ Date _____