2817 EL CAMINO REAL
SANTA CLARA, CA 95051
Tel: 408-984-2020

EYE BOUTIQUE
OPTOMETRY

PATIENT INFORMATION: (*NEW PATIENT, or ESTABLISHED PATIENTS if only your information has CHANGED*)			
First Name: Last Name: G: F M		Email:	
Cell #:	Work #:	Birth Date:	SS#
Address:		City/State/Zip:	

How were you referred to our office? ○ Yelp/Google/Facebook ○ Insurance ○ Family/Friend ○ Other _____

Occupation: □ Employed □ Retired □ Full-Time Student □ Other_____ Status: □ Married □ Single

Do you want to set up an appointment for next year? □ Make an appointment □ Text or Email me when it's time

Vision Insurance	**Secondary Vision Insurance**(if applicable)
Vision Insurance Company:	Vision Insurance Company:
Primary Insured's Name:	Primary Insured's Name:
Primary Insured's ID# OR SS#:	Primary Insured's ID# OR SS#:
Primary Insured's Birth Date:	Primary Insured's Birth Date:
Primary Insured's Phone:	Primary Insured's Phone:
Relationship to patient:	Relationship to patient:

Medical Insurance □ PPO □ HMO □ MEDICARE □ OTHER (please bring medical card so we may make a copy to include in your records.)	
Medical Insurance Company:	Second Medical Insurance Company:
Primary Insured's Name:	Primary Insured's Name:
Primary Insured's ID# OR SS#:	Primary Insured's ID# OR SS#:
Primary Insured's Birth Date:	Primary Insured's Birth Date:
Relationship to patient:	Relationship to patient:

Main reason for visit (Please check)

_____ Blurred vision _____General Eye Exam _____ Headache or eye fatigue _____ New eye glasses

_____ Red eye/Dry eye _____Contact lenses _____OrthoK(Myopia Control) _____ Lasik Other_____

*Have **YOU** or any **FAMILY MEMBERS** (blood relatives only) ever been diagnosed as having any of the following? (Please check all that apply)*

*or if **NONE** APPLY please check here -> □*

	Self	Family		Self	Family		Self	Family		Self	Family		Self	Family
Glaucoma	□	□	Blindness	□	□	Eye injury	□	□	Diabetes	□	□	Cancer	□	□
Cataract	□	□	Retinal Disease	□	□	Lazy/Crossed Eyes	□	□	High Cholesterol	□	□	Heart disease	□	□
Macuar Degeneration	□	□	Corneal Disease	□	□	Thyroid Disease	□	□	High blood pressure	□	□	Autoimmune Disorder	□	□

□ Are there any other medical conditions or eye disorders that the doctor should be aware of (please list)? _____

_____

□ Please list any **MEDICATIONS/SUPPLEMENTS** that you take: _____

□ Do you have ALLERGIES to any medication, materials or substances? Yes / No If yes, please list: _____

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby Eye Boutique Optometry to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This is includes but not limited to my Insurance Company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT: I/We hear by authorize Eye Boutique Optometry to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges/copay in full on the date of service. As a courtesy, my vision or medical insurance will be billed for me. It is my responsibility to pay any deductible, copay, or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Signature: _____ **Date:** _____

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operation. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA(Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operation.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However. Such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operation.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use od the information but practice does not have the agree to those restrictions.
- The patient has the right to revoke this consenting writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date:_____

Relationship to patient(if signed by a person representative of patient): _____