

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Birth Date: ____/____/____ Social Security (opt): _____
 Occupation: _____ Employer: _____
 Primary Care Physician: _____
 PCP Address: _____
 Previous Eye Physician: _____

Guardian (If applicable): _____
 Today's Date: ____/____/____
 Home Phone: _____ - _____ - _____
 Email: _____
 Work Phone: _____ - _____ - _____
 Cell Phone: _____ - _____ - _____
 Last Medical Exam: _____
 Last Eye Exam: _____

How did you hear about us? _____

Was the HIPPA – Notice of Privacy Practices form made available to you? _____ (Please initial)

1) EYE CHIEF COMPLAINT (TODAY)

Blurred Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Foreign Body Sensation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Burning	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glare/ Light sensitivity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye/ Lid Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Itching	Yes <input type="checkbox"/> No <input type="checkbox"/>
Distorted Vision/ Halos	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of Side Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Double Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dryness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mucous Discharge	Yes <input type="checkbox"/> No <input type="checkbox"/>
Excess Tearing/ Watering	Yes <input type="checkbox"/> No <input type="checkbox"/>	Redness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye Pain/ Soreness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sandy/ Gritty Feeling	Yes <input type="checkbox"/> No <input type="checkbox"/>
Flashes/ Floaters in Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tired Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you answered *Yes* to any of the above or have a condition not listed, please explain: _____

2) OCULAR CONDITIONS

Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blindness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Crossed Eyes/Strabismus	Yes <input type="checkbox"/> No <input type="checkbox"/>
Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lazy Eye/Amblyopia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetic Retinopathy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retinal Disease/Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dry Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Ocular Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Refractive Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>

3) MEDICAL HISTORY

Do you have any allergies or allergies to medication? _____

List ANY medications you take prescription or over the counter: _____

List ALL current health conditions: _____

List ALL major injuries, surgeries and hospitalization: _____

Are you pregnant or nursing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	How old is your present pair?	_____
Do you wear glasses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	How old is your current pair?	_____
Do you wear contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you sleep in them?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What type of contact lenses?	Hard <input type="checkbox"/> Soft <input type="checkbox"/>	How often do you change/dispose of your CL?	_____
Are they comfortable?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Interested in refractive surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

4) FAMILY HISTORY

Disease/ Condition: _____ If yes, please indicate which relative; specify maternal or paternal if necessary

Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Eye Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Retinal Detachment/Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Other Diseases	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Blindness	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Crossed Eye/Lazy Eye	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Lupus	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

5) SOCIAL HISTORY

Do you drive? Yes No

Any visual difficulties? Yes No

If yes please explain _____

Do you use tobacco/e-cigarette? Yes No If yes, what type/ amount/ how long? _____

Do you use illegal drugs Yes No If yes, what type/ amount/ how long? _____

Do you drink alcohol? Yes No If yes, how often? _____

Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV? Yes No

6) REVIEW OF SYMPTOMS (Do you currently have the following):

CONSTITUTIONAL		MUSCULOSKELETAL	
Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis/Rheumatoid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoarthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Gain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle/Joint Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
CARDIOVASCULAR/VASCULAR		INTEGUMENTARY (Skin)	
Heart Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	PXE (Pseudoxanthoma Elasti)	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	NEUROLOGICAL	
Vascular Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headache	Yes <input type="checkbox"/> No <input type="checkbox"/>
EAR, NOSE, MOUTH, THROAT		Migraine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies/ Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	PSYCHIATRIC	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dry Mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	ENDOCRINE	
Ear Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sinus Congestion	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, your most recent blood sugar level? _____	
RESPIRATORY		Thyroid/ Other Glands	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC	
Bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bleeding Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
GASTROINTESTINAL		IMMUNOLOGY	
Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Syphilis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
GENITOURINARY		ALLERGIES	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bladder	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Kidney	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Medical Eye Exam to detect/rule out ocular and retinal diseases is recommended on annual basis through dilated fundus exam (DFE), photos, visual field testings (VF) or OCT scan. These elective services might not be covered/partially covered by your medical insurance.

Reschedule to a later date Consent for DFE VF Photos OCT Scan Medical Eye Exam

Patient/Guardian Signature: _____ Date: ____/____/____

Contact Lens Policy

Warning: If you are having any unexplained eye discomfort, watering, vision change/or redness, remove your lenses immediately and consult your eye care practitioner before wearing your lenses again.

Contact lens trials that are dispensed REQUIRE a contact lens follow-up before contact lens prescription can be finalized; unless it has been verified that patient has been wearing the same contact lens previously. Patient needs to have the contact lens in for a minimum of 2 hours before the appointment to ensure proper contact lens follow-up evaluation. This follow-up needs to be WITHIN 30 DAYS of the initial contact lens dispensed. AFTER 30 DAYS, patient will be responsible for an office visit fee.

It is considered another contact lens fitting if any changes requested be made to a FINALIZED H2T contact lens Rx. (Changing brands or colors)

If contact lens supply is ordered through H2T office, exchanges are only granted to UNOPENED and UNMARKED boxes. If contact lens supply is ordered elsewhere, H2T will not offer any exchanges.

Glasses/ Frame Policy

ANY H2T prescription sunglasses or glasses will have a 30 DAYS adaptation period. WITHIN 30 DAYS OF THE EXAM DATE, patient is responsible for scheduling a glasses follow-up appointment if he/she is having problems with their prescription. AFTER the 30 DAYS, there will be an office visit fee for a prescription recheck. There will be a charge for verification of glasses purchases elsewhere with H2T prescription.

NO RETURNS are granted once a purchase is made. There are NO EXCHANGES for any purchased non-prescription glasses, sunglasses or accessories.

H2T is not responsible for any scratched, chipped or broken frame that is not considered a manufacturer defect. Lenses or frames will be sent out for verification. There will be a fee to have the lenses or frames replaced.

If patient prefers to provide a frame and have H2T fit lenses to the frame, H2T is NOT RESPONSIBLE for any damages to the frame. \$40 Co-pay applies if patient chooses to use own frame.

H2T is not liable for any frame adjustments that is not purchased through H2T. This is a PAID service and H2T are NOT LIABLE for any damages or scratches that could happen during this service.

No Show/ Cancellation Policy

ALL scheduled no show appointments will be charged \$50.00 no show fee. Patient is responsible to CALL the office to reschedule or cancel any appointment at least 24 hours in advance.

H2T Office Policy

Photo ID required for insurance and physical address verification. Vision or Medical cards are required at the time of service for continuation of care. Patient is responsible to notify H2T any insurance changes. Any unverified insurance information will result in the visit being a self-pay visit.

There will be a \$15 fee for medical record per request.

H2T utilizes electronic communications either through email or text messaging. Patient has the option to opt-out of these communication at anytime by following the instructions on the electronic communications received.

H2T DOES NOT participate with any workman's compensation companies.

I, _____, have read, understand and acknowledge the policies stated above.

Signature _____

Date: _____