Broadway Vision Source

A Member of

Registration Form

Today's Date ________________

Patient Information

Name ____________________ Birth date ____________________

Address ____________________ Employer ____________________

City/State/Zip Code ____________________ Occupation ____________________

Guardian (if applicable) ____________________ Home Phone ____________________

E-mail address ____________________ Work Phone ____________________

Cell Phone ____________________

Person to be contacted in case of emergency (local friend or relative)

Name ____________________ Relationship ____________________

Phone ____________________ E-mail Address ____________________

Payment Policy

- Payment is due in full for professional services on the day of your examination
- Payment of ½ the total cost of any merchandise (eg; glasses, contact lenses) is required when the order is placed. The balance is due in full upon receipt of the merchandise
- We do not provide payment plans (exception: CareCard)
- Bankcards accepted: MasterCard, Visa, American Express

Insurance Benefits

For those with health insurance:

Vision insurance may be an *optional* coverage under your health plan (similar to dental coverage). Please verify that you are covered for vision. Please also be aware that insurance eligibility information given to us by your insurance company is not a guarantee of coverage. Any balance is the sole responsibility of the bill payer.

I authorize Broadway Vision Source or the insurance company to release information required to process my claim. I authorize my insurance benefits to be paid directly to Broadway Vision Source. I accept financial responsibility for all account balances. I understand an annual interest rate of 12%, 1% per month, or a minimum re-billing fee of $2.00 per month will be applied to all patient- responsible balances over 90 days.

Signed (Guarantor) ____________________ Date: ____________________

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Health History

Today's Date:_______________

Patient Name:____**Birthdate:**________________

Sex________**Pronouns** _______________

Race:

___African American
___American Indian or Alaskan Native
___Asian
___White
___Hispanic
___Native Hawaiian or Other Pacific Islander

Ethnicity:

___Hispanic or Latino
___Not Hispanic or Latino
___Native Hawaiian or Other Pacific Islander

Primary Care Physician:____

Medical/Family History

Please list all your current medications (including over-the-counter, vitamins, and/or herbal therapy):

____
____
____

List any adverse or allergic reactions to medications or eye drops:____
____

List all major surgeries (including eye surgery):____
____

Please indicate if any of these conditions apply to you or a blood relative:

Disease/Condition	Yourself	Family Member	Relationship (specify Paternal/Maternal)
Blindness	_____	__________	__________
Cataract	_____	__________	__________
Glaucoma	_____	__________	__________
Macular Degeneration	_____	__________	__________
Retinal Detachment	_____	__________	__________
Strabismus (eyes are not aligned with one another)	_____	__________	__________

Review of Systems

Please indicate below if you have any of the following conditions (with or without medication):

Are you pregnant? Yes ☐ No ☐

Are you breast feeding? Yes ☐ No ☐

Allergic/Immunologic

_____None
_____Lupus (SLE)
_____Rheumatoid Arthritis
_____Environmental Allergies
_____Seasonal Allergies
Other (eg; Latex): ____________________

Endocrine

_____None
_____Diabetes
_____Hormone Dysfunction
_____Thyroid Dysfunction
Other____________________

Genital/Urinary

_____None
_____Herpes/Chlamydia
_____HIV Positive
_____Urinary Tract Infection (existing)
Other____________________

Neurological

_____None
_____Epilepsy
_____Multiple Sclerosis
_____Tremors
Other ____________________

Cardiovascular

_____None
_____High Blood Pressure
_____High Cholesterol
_____Heart Disease
_____Stroke
_____Vascular Disease
Other____________________

Gastrointestinal

_____None
_____Acid Reflux/Ulcer
_____Colitis
_____Crohn's Disease
Other ____________________

Hematologic/Lymphatic

_____None
_____Anemia
_____Bleeding Disorder
_____Leukemia
Other____________________

Psychiatric

_____None
_____Anxiety Reaction
_____Bipolar
_____Depression
_____Schizophrenia
Other____________________

Ear, Nose, Throat

_____None
_____Sinusitis
_____Upper Respiratory Infection
Other____________________

General Health

_____None
_____Cancer
_____Fatigue
_____Fever
_____Trauma
_____Weight loss/gain (20+ lbs)
Other____________________

Muscle/Skeletal

_____None
_____Arthritis
_____Ankylosing Spondylitis
_____Fibromyalgia
Other____________________

Respiratory

_____None
_____Asthma
_____Bronchitis
_____Emphysema
Other____________________

Social

Tobacco Use: None ☐ Current ☐ Packs per day: For how long?
Former ☐ Packs per day: For how long? When did you quit?

Marijuana: ☐
Recreational Drug(s): ☐
Alcohol: ☐ Frequency per week/quantity:

Chief Vision/Ocular Complaint:

	Date of Onset (approximate)	Worsening	Improving
____Annual Exam (no complaints)			
____Blurry Vision at Distance	____________________	_____	_____
____Blurry Vision at Near	____________________	_____	_____
____Blurry Vision General	____________________	_____	_____
____Bump/Growth on Lid(s)	____________________	_____	_____
____Double Vision	____________________	_____	_____
____Dry Eye(s)	____________________	_____	_____
____Extreme Light Sensitivity	____________________	_____	_____
____Eye Infection	____________________	_____	_____
____Eye Pain	____________________	_____	_____
____Flashes	____________________	_____	_____
____Floaters	____________________	_____	_____
____Headaches	____________________	_____	_____
____Itchy Eye(s)	____________________	_____	_____
____Loss of Vision	____________________	_____	_____
____Red Eye(s)	____________________	_____	_____

____Other (please elaborate): ____

Please sign below to acknowledge that this form is current:

Signature:____Date:_______________

Acknowledgment of Receipt of Notice of Privacy Practices

My signature below verifies that I have received a copy of the Broadway Vision Source Notice of Privacy Practices.

Name of Patient (print):____

Signature:____Date: _______________

Signature of Patient Representative (if patient is a minor or an adult unable to sign this form)

____Date: _______________

Relationship of Patient Representative to Patient:___________________________

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Retinal Health

Retinal Imaging (Optomap) vs. Pupillary Dilation

During your comprehensive eye examination, your doctor will view the inside of your eyes to evaluate your retina. Pupillary dilation has long been the conventional method for doing this. Broadway Vision Source offers an alternative method of retinal evaluation, called Retinal Imaging. In this method, the retina is digitally imaged using an instrument called Optomap.

See below for the differences between pupillary dilation and Retinal Imaging (Optomap). Both options allow the doctor to thoroughly examine the integrity and health of the retina.

Retinal Imaging (Optomap)

The optometric technician will take several images of each eye, which include bright flashes. The benefits of this method include:

- Photo-documentation and secure storage of image data, which allows for side-by-side comparisons of your retina over time to track changes
- Enables the doctor to review and present retinal findings during exams
- Allows the doctor to share retinal images with you and other clinics

Retinal Imaging for patients 45 years old and older involves additional imaging, called Optical Coherence Tomography (OCT). OCT imaging provides a high resolution, cross-sectional scan of selected areas of the retina. This enables the doctor to detect early changes, which may indicate retinal diseases such as macular degeneration and glaucoma. The cost of OCT is an additional $13, for a total retinal imaging fee of $49 + $13 = $62.

Pupillary Dilation

The doctor will instill dilating eye drops, which takes about 20 minutes to take effect and lasts approximately 6-8 hours. Side effects include:

- Blurred vision, especially close-up
- Light sensitivity (temporary sunglasses provided)
- Mild stinging upon instillation

Indicate whether you would like us to utilize Optomap (and Optovue OCT if applicable) for your examination by checking the appropriate item below. If you have any questions or concerns regarding this, you may leave this blank and discuss with the optometric assistant or doctor during your exam.

Please mark <u>one</u> of the below options:

☐ I elect to have Retinal Imaging

Patients ages 0-44: $49
Patients ages 45+: $62
Retinal imaging is sometimes covered by insurance.

☐ I prefer pupil dilation

Included in exam cost

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Contact Lenses

Please read and complete this page if you wear contact lenses or are interested in wearing contact lenses. Contact lenses are federally-regulated devices. Broadway Vision Source's policies (below) comply with all requirements outlined in the Contact Lens Rule (16 Code of Federal Regulations Part 315).

1. Indicate the type of contact lenses you currently wear: ☐ Rigid ☐ Soft Other ______________
2. Where was your last prescription obtained
   (not to be confused with where you obtained your contact lenses)? ________________________

If you currently wear/want to wear contact lenses and would like to have your contact lens prescription updated/ renewed, the fee for an evaluation is **$86.00** (if the doctor determines that a new type or brand of contact lens will better suit your needs, more evaluation time will be needed, and an additional fee will be charged).

The contact lens evaluation involves determining the correct power of your contact lens prescription (which is different from your glasses prescription). The doctor will also evaluate the potential or existing risks associated with contact lens wear. These findings are reviewed with you to apprise you of any changes and ensure your contact lens success.

Please mark one of the below options:

☐ I choose to have my contact lenses evaluated and contact lens prescription renewed/created.

☐ I choose **not** to have a contact lens evaluation performed*.

*By WA state regulation, contact lens prescriptions are valid for 2 years.
Contact lens prescriptions will not be renewed unless an evaluation is performed.