



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: _____



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 _____

Social

Tobacco Use: None Current Packs per day: For how long?
 Former Packs per day: For how long?

Marijuana:

Recreational Drug(s):

Alcohol:

Frequency per week/quantity:

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 _____

When did you quit?

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: _____

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 \$10, for a total retinal imaging fee of \$37 + \$10 = \$47.

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 one of the below options:

I elect to have Retinal Imaging

Patients ages 0-44: \$37

Patients ages 45+: \$47

Retinal imaging is sometimes covered by insurance.

I prefer pupil dilation

Included in exam cost



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 **\$65.00** (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.