PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions

Today's Date _____ Gender Male Female Social Security _____-_____-_____ Date of Birth ____/____ /____
Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Phone_____ Cell Phone_____ Alternate Phone _____
Email _____ Married /Separated/ Widow/ Single/ Divorced/ Minor
Occupation _____ Employer _____
Emergency Contact _____ Phone Number _____ Relation _____

Insurance Information
Name of Vision Insurance _____
Primary Member : First Name_____ Last Name _____
Relationship _____ Date of Birth _____ /_____ /_____ Social Security #_____

Medical Information
How is your general health? _____
Diabetes Yes/No _____Type _____ Date of diagnosis _____
Allergies to medication Yes/No Kind? _____ Reactions? _____
Current medication (s)_____
Any other Medical History _____
Do you use: Cigarette/Tobacco_____ Alcohol_____ Other Substance _____

Self/Family History (Under "Relation", write "Self" for yourself or indicate which family member)

Diabetes	Yes	No	Relation_____	Endocrine gland	Yes	No	Relation _____
High blood pressure	Yes	No	Relation _____	Cardiovascular	Yes	No	Relation _____
Thyroid	Yes	No	Relation _____	Respiratory	Yes	No	Relation _____
Cataract	Yes	No	Relation _____	Immunological Disease	Yes	No	Relation _____
Glaucoma	Yes	No	Relation _____				

Personal Eye Information
Date of last Exam _____/_____/_____ Location _____
Do you wear glasses? (circle) Yes No
Contact lenses?(circle) Yes No Are you wearing them now? Yes No Type/Name: _____
Are you satisfied with your : Glasses _____ Contact lens _____ LASIK _____
About how many hours a day do you use the computer? _____
Are you having any issues seeing far or near? _____
Do you have any specific visual needs? _____
Have you had any eye operations? Yes No Type: _____Date: _____
Do you have any of the following symptoms?
_____ Tearing _____ Keratoconus _____ Itching _____ Red Eye
_____ Burning _____ Dry Eye _____ Eye Pain _____ Cross eye/Lazy eye/Amblyopia
_____ Flashes of light/Floater (Circle which one)
How often do you experience them? _____ How long do they last? _____
_____ Headaches When do you experience them? _____ How long do they last? _____
Where do you feel them? (temples, forehead, etc.) _____ What alleviates them? _____
Last Dilated Fundus Exam Date: _____/_____/_____
Activities and Sports: _____
Is there any friends or family you would like to refer to us? _____
Would you be interested in signing up for Care Credit? _____

Crystal Vision Optometry

Patients must initial beside each statement to acknowledge the policy and then sign at the bottom of the page

OFFICE POLICY

In order to maintain economical profesional fees and material charges, the following office policy stands:

A. When only **professional fees** are incurred, payment is expected at the time of service. ___ ***Initial***
B. When **professional fees** and **material charges** are incurred, **total payment** is required before the order can be placed. ___ ***Initial***
C. When only **material charges** are incurred (glasses or contacts) **total payment** is required before the order can be placed. ___ ***Initial***
D. All services and sales are **FINAL.** There are **no refunds or exchanges.** ___ ***Initial***
E. We cannot be responsible for delays due to breakage and /or manufacturer back-ordered materials. Please note: We have no control over delays/loss of items via the United States Postal Service (USPS), United Parcel Service (UPS), or other Carrier organizations. ___ ***Initial***
F. Any dissatisfaction with lenses/frames must be brought to our attention within 30 days of dispensing/delivery for valid/appropriate assessment. ___ ***Initial***
G. In the unlikely event that your visual system cannot tolerate certain styles of multi-focal lenses (if needed):

1. **Progressive lenses** can be substituted with a pair of conventional trifocal or bifocal lenses at no additional cost to you.
2. **Trifocal lenses** can be substituted with a pair of conventional bifocal lenses at no additional cost.
3. **Bifocal lenses** can be substituted with a pair of single vision distance or near lenses at no additional cost.
4. Please note: No refunds will be made on the difference between multifocal style charges. Lens substitutions are comparable for tints, coatings, etc. ___ ***Initial***

H. Written contact lens prescriptions are obtainable after completion of the fitting period for established fits only. The follow-up visit is included in the quoted cost for contact lens fitting. Contact lens fittings are performed strictly within 3 months from your eye exam and follow-up visits must be completed within 3 months of the fitting to avoid additional charges for re-fit and/or an additional eye exam. ___ ***Initial***
I. When using old frames for prescription lenses, neither we nor our optical laboratories can accept responsibility for frame damage in the process of handling. ___ ***Initial***
J. Frames/ spectacle lenses lose their ability to withstand the pressure of adjustments/repairs with time. While we use the utmost care, we are not responsible for any damages incurred during the process. ___ ***Initial***
K. Scratch resistant lens coatings are just that, **resistant**, and not scratch-proof. ___ ***Initial***
L. Orders that have not been dispensed/picked-up after 3 months from the first attempt of notice will be discarded, restocked, or donated to charity. ___ ***Initial***

FINANCIAL RESPONSIBILITY

We accept most insurances and will do our best to pull the authorization and submit billing. Verification for eligibility of benefits is not a guarantee of payment. The undersigned authorizes direct payment to Dr. Adhikari, with any insurance benefits otherwise payable to the undersigned, for Dr. Adhikari's services. It is the patient's responsibility to pay for services and materials not covered by insurance.

REFERRAL ACKNOWLEDGEMENT

A referral for further evaluation/treatment may be made when a potential problem exists that could have significant consequences if not appropriately addressed. While we use the utmost care, we cannot absolutely guarantee that all referral letters, phone calls, or faxes are received. We make the referral in good faith and with acknowledgement. In order to safeguard your well-being, it is incumbent upon you to contact us if you have not obtained your referral appointment in a timely fashion. The ultimate decision/responsibility to keep the appointment is always yours.

RETURN VISIT ACKNOWLEDGMENT

A return visit to our office to further evaluate, monitor, or treat a present condition is made in good faith. Without further follow-up visits, some conditions may have consequences that could lead to blindness or be a threat to your health. When appointments made for further check-ups are not kept, the responsibility for the condition becomes yours.

Please read and sign back side of this page

Crystal Vision Optometry

PATIENT'S OR AUTHORIZED GUARDIAN SIGNATURE

I authorize the release of any medical or other information necessary to process this transaction. I also authorize any insurance benefits to be paid to Dr. Adhikari. I understand that if in the event my insurance carrier pays less than the actual bill for the services that have been provided to me. I agree to be responsible for payment of all services and/or materials rendered on my behalf and/or my dependent(s). I have read and understand the content of these two pages.

_____	_____	_____
Signature of patient (or parent/guardian if a minor)	Relationship	Date

HIPAA NOTICE OF PRIVACY PRACTICES

Crystal Vision Optometry
(909)980-5552
11940 E. Foothill Blvd, Suite 103, Rancho Cucamonga, Ca 91739

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read this notice carefully. If you have any questions, please contact our Office Privacy Officer.

We are required by law to: (a) Make sure that health information that identifies you is kept private. (b) Give you this Notice of our legal duties and privacy practices with respect to health information about you. (c) Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you: (1) For treatment. (2) For payment. (3) For health care operations. (4) For Appointment reminders. (5) As required by Law. (6) To avert a serious threat to health and safety. (7) As required by the Military or Veterans and Workers Compensation. (8) Lawsuits and disputes. (9) Law enforcement. (10) Government Agencies. (11) Security Officials for Inmates. (12) Business Associates. (13) Our submission of your health information to auditors hired by third-party payers and insurers.

Your rights regarding Health Information about you: (1) Right to Inspect and copy. (2) Right to Amend. (3) Right to an Accounting of Disclosures.. (4) Right to Request Restrictions. (5) Right to Request Confidential Communication. (6) Right to a Paper copy of this notice (full Notices is available upon request).

Changes to the Notice:
We reserve the right to change the Notice. We will post a copy of the current notices in our facility with the current effective date on the first page.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the Privacy Officer to file a complaint.

Acknowledgement of Receipt of this Notice:
I have read this document and understand it. I consent to the use and disclosure of my health information.

Signature_____Date_____

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