PRO OPTIX WELCOMES YOU TO OUR OFFICE!

Name: (Last)_____(First)_____ Age:___ Date of birth: _____/_____/_____
Address:_____
Cell Tel: (____) _____-_____ Home Tel: (____) _____-_____Email:_____
Parent/Guardian (if under age 21 or disabled):_____
How did you hear about us? ☐ PCP ☐ Advertisement ☐ Social media ☐ Other:_____

VISION HISTORY
Reason for your Visit: ☐ Routine eye exam ☐ Medical issue _____
☐ *Contact Lens Fitting (****NOTE: this is a **separate** service from the routine eye exam, please consult with reception for information before services are rendered)*
Date of Last eye exam:_____ Doctor/clinic:_____
Do you wear glasses? ☐ No ☐ Yes Contact Lenses? ☐ No ☐ Yes
Have you had eye surgery? ☐ No ☐ Yes Which eye? _____ Type of surgery?_____

GENERAL HEALTH HISTORY
Name of Primary Care Doctor: _____Tel: (___) ____-____Address:_____
Current smoker: ☐ No ☐ Yes Former smoker: ☐ No ☐ Yes
Are you currently being treated for any medical conditions? ☐ No ☐ Yes
If yes, which conditions: ☐ Diabetes ☐ Blood pressure ☐ Cholesterol ☐ Thyroid disorder ☐ Prostate E.
☐ Lupus ☐ Rheumatoid arthritis ☐ Multiple Sclerosis ☐ Sickle cell ☐ HIV ☐ Hepatitis A/B/C
☐ other:_____
List all medications taken:_____
Allergies: ☐ No ☐ Yes List: _____
FAMILY HEALTH & OCULAR HISTORY (diabetes, glaucoma, macular degeneration, cataracts, hypertension, cancer):_____

INSURANCE SIGNATURE ON FILE & NOTICE OF PRIVACY PRACTICES

I request that payment of authorized insurance benefits be made either to me or on my behalf to this Vision Center provider for any services rendered. I authorize any holder of my medical information to be released to the Health Care Financing Administration (CMS), insurance cie and its agents if needed to determine these benefits payable for related services. I authorize that my medical records be released when requested by such agents and/or to medical practitioners responsible for the comanagement of my medical care. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information. We are required to abide by the terms of the notice currently in effect. We reserve the right to change the terms of our notice at any time and to make the new notice provisions effective for all protected health information that we maintain. In the event that we make a material revision to the terms of our notice, you will receive a revised notice within 60 days of such revision.

POLICIES

-Minimum of 50% is required as a deposit when ordering eyeglasses, full payment required for contact lenses.
-All insurance copays for professional services and/or materials are collected up front and are NON-refundable.
-When electing to use your own eye-frame, we are NOT responsible for any possible breakage, loss or replacement.
-No personal checks are accepted when picking up ordered eyewear or contact lenses.
-Ordered eyewear must be picked up within 90 days. Deposits will be forfeited after 90 days.
-Non-adaptation to progressive lenses is NOT a basis for exchanges or refunds.
-Polycarbonate waiver of liability: we STRONGLY recommend that all patients age 18 and under and monocular seeing patients choose polycarbonate lenses for security and medical reasons. We are NOT responsible for any injuries or lack of warranty if you chose not to purchase polycarbonate.
-Contact lens fitting includes: The Initial fit, *ONE* follow up visit, one I&R session. Additional follow ups are 35$
-All sales are FINAL: NO refunds, some Exchanges only with restocking fee of 20%. PRESCRIPTION EYEWEAR AND GLASSES ARE CUSTOM MADE, ORDERS CANNOT BE CANCELLED OR RETURNED.

Signature on file:_____ Date:_____

Please complete the backside of this form

FDT VISUAL FIELD TESTING

The FDT VISUAL FIELD ANALYZER is like a scan of the eye and visual system that can detect diseases of which patients may not be aware of.

Dr. Pacheco and Dr. Demarco STRONGLY RECOMMEND that all patients pass this test at least *once a year*. It is especially important for:

- NEW patients
- CHILDREN
- HEADACHES
- History of High Blood Pressure and/or Diabetes
- Family history of glaucoma or other eye diseases

The FDT VISUAL FIELD ANALYZER can help *detect*:

- ✓ Tumors (pituitary, glioma, etc)
- ✓ Strokes or aneurysms
- ✓ Glaucoma
- ✓ Macular degeneration
- ✓ Cataracts
- ✓ Optic nerve disease
- ✓ Retina disease
- ✓ Medications side-effects

This test requires a fee of only $15.00 which is NOT covered by insurance

I have read and understand the benefits of this recommended test:

(I AGREE to this procedure

(I DECLINE this procedure

Patient signature: _____

Date: _____/_____/_____

1205 S Powerline Rd, Pompano Beach, FL. 33069

Please complete the backside of this form