OPAL OPTOMETRY | Dr. Caitlyn Rana-Lew, OD
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Welcome to Opal Optometry!

Date: _____

Patient Information

Patient Name: _____ Date of Birth: ____/____/_____
Preferred Name: _____ Sex: ☐ F ☐ M ☐ X
Mailing Address: _____ Cell Phone: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Email Address: _____ Opt-In for text message reminders? ☐ Yes ☐ No
Occupation: _____ Preferred Language (if not English): _____
Parent/Guardian (if patient is under 18): _____ Phone: _____
Emergency Contact & Relationship: _____ Phone: _____
How did you hear about us? _____

Insurance Information

Vision Benefits Company: _____ Member ID#: _____
Primary Member Name: _____ Primary Member Date of Birth: ____/____/_____
Secondary vision coverage? ☐ Yes ☐ No Secondary vision plan name & policy holder: _____

Medical History

Have you or any blood relatives been diagnosed with any of the following? List the family member or add details to explain.

	You	Family	Relationship or Explain
Medical Conditions			
Autoimmune Disease	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Hay Fever (Allergies)	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Migraines	☐	☐	
Neurological Disorders	☐	☐	
Stroke	☐	☐	
Thyroid Disease	☐	☐	
Other: _____	☐	☐	
Eye Conditions			
Cataracts	☐	☐	
Glaucoma	☐	☐	
Dry Eye	☐	☐	
Retinal Detachment	☐	☐	
Macular Degeneration	☐	☐	
Keratoconus	☐	☐	
Strabismus (Eye Turn)	☐	☐	
Amblyopia (Lazy Eye)	☐	☐	
Blindness	☐	☐	
Other: _____	☐	☐	

Primary Care Physician / Pediatrician: _____
Phone: _____ Date of Last Physical: _____
Medications (including OTC, eye drops, vitamins): _____

Do you take any of these?
☐ Plaquenil ☐ Steroids ☐ Flomax ☐ Amiodarone ☐ Topamax ☐ None

Allergies to medications or eye drops? _____
Do you smoke or vape? ☐ Yes ☐ No How often? _____
Pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

Date of Last Eye Exam: _____
Do you wear glasses? ☐ Yes ☐ No Contacts? ☐ Yes ☐ No
Contact Lens Brand: _____
Any past eye injuries or surgeries? ☐ Yes ☐ No
If yes, please explain: _____

Consent to Dilation

Opal Optometry recommends a dilated eye examination every year, or as medically indicated. Dilating drops enlarge the pupil so the doctor can thoroughly examine the retina and optic nerve. Dilation helps detect eye diseases such as glaucoma, macular degeneration, and retinal tears, as well as signs of systemic conditions such as diabetes and high blood pressure. For children, special drops also relax the focusing muscles so we can accurately measure the eyes' true prescription.

Dilation usually causes blurry vision, especially up close, and light sensitivity for 4 to 6 hours, and sometimes longer in children. We recommend bringing sunglasses and arranging a driver if you are uncomfortable driving with blurred vision. Please initial below.

☐ **YES**, I would like my (or my child's) eyes dilated today during my eye exam if recommended by the doctor.

☐ **NO**, I do not want dilation today. I understand this may limit the doctor's ability to fully evaluate eye health.

Prescription Release Acknowledgement

I understand that I will be provided with a copy of my glasses and/or contact lens prescription following the completion of my refractive eye exam or contact lens fitting.

I consent to have my eyeglasses and/or contact lens prescription sent to me electronically by **email.**

☐ **Yes** ☐ **No** ☐ **I prefer a printed copy**

Financial Policy, Assignment of Benefits & Release of Information

Insurance. Opal Optometry extends the courtesy of filing claims to your vision and medical insurance plans. Please keep in mind that insurance coverage is a contract between you and your insurance company, and a benefits quote from your plan is not a guarantee of payment.

Medical and vision billing. I understand that my visit may be billed to my medical insurance, instead of my vision plan, when the doctor evaluates or manages a medical eye condition. Refraction (the test that determines a glasses prescription) is not covered by many medical plans; when it is not covered, I am responsible for the practice's usual and customary (U&C) refraction charge. Contact lens evaluation and fitting are separate from the routine eye exam and may carry an additional fee.

Patients without insurance. If I do not have insurance or choose not to use it, I understand that I have the right to request a Good Faith Estimate of expected charges before my visit.

Missed appointments. We kindly ask for at least 24 hours' notice to cancel or reschedule an appointment so that we can offer the time to another patient. Appointments that are missed or canceled without this notice may be subject to a fee, and we may be unable to offer a rescheduled appointment.

Financial responsibility. I understand and agree that I am ultimately responsible for all payment obligations arising from services and products provided to me or my dependents. I agree to pay all co-payments, deductibles, coinsurance, and charges not covered by my insurance plan at the time of service, or upon receipt of a statement, unless other payment arrangements have been made in advance. If a claim is denied or reduced, I remain responsible for the balance, except where our agreement with my plan or the law does not permit billing me. If a balance remains unpaid 60 days after my statement date, I understand that a late fee may be applied, where permitted by law, and the account may be referred to a collection agency.

Assignment of Benefits. I hereby assign and direct payment of any vision, medical, and other insurance benefits directly to Dr. Caitlyn Rana-Lew, O.D., Optometric Corporation, doing business as Opal Optometry, for services rendered to me or my dependents.

Release of Information. I authorize Opal Optometry to release any medical, clinical, or billing information concerning my treatment to my insurance carrier(s), Medicare, Medi-Cal, and their authorized agents, as necessary to process claims or determine payable benefits. This authorization remains valid until I revoke it in writing, except to the extent action has already been taken in reliance on it.

Acknowledgement of Privacy Policy

In the course of providing care to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information to treat you, to obtain payment for services, and to conduct health care operations in our office. Our Notice of Privacy Practices describes these uses and disclosures, and your rights, in detail.

Consent to Treatment

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor/s to examine, diagnose and initiate treatment as deemed appropriate. I further attest that if that patient is a minor, I am the Parent or Legal Guardian of Minor and have the authority to authorize care and treatment.

My signature below confirms that I have read, understand, and agree to all sections of this form: Dilation, Prescription Release, Financial Policy, Privacy Policy, and Consent to Treatment.

Signature of Patient or Guardian (if under 18 yrs):_____ Date: _____

Patient Printed Name:_____