EYE PHYSICIANS OF LONG BEACH

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Phone 562.421.2757 Fax 562.420.7267

Optomap or Eye Dilation

As part of a comprehensive eye examination, it is recommended that **ALL** patients have the internal health of their eyes thoroughly evaluated. This is performed either as a dilated retina exam or with the **Optomap Retinal Imaging** camera. Dilation of pupils with eye drops is still considered the most complete way of viewing the retina.

Our physicians are committed to discovering and documenting eye problems such as **macular degeneration, diabetic retinopathy, glaucoma, retinal holes, or detachments** (all of which can lead to partial loss of vision or blindness). Systemic diseases such as high blood pressure and diabetes can also be discovered during the retinal exam. Due to a limited view of the internal structures of the eye, these health conditions are difficult to detect (and potentially treat) without the **Optomap Retinal Imaging** camera or dilation of the pupils.

Optomap:

- Provides an eye wellness scan.
- It allows your doctor to review your **Optomap** Retinal Image with you.
- Provides an annual, permanent record.
- Gives an in-depth view of the retinal layers (where disease can start)
- It is fast, easy, and comfortable.
- **Will NOT require dilating drop** (drop would result in light sensitivity and blurred vision for 4-6 hours).

Some patients may need to have their eyes dilated also; this is dependent on what your doctor determines is best for your eyes. Example: You will need to be dilated if you are coming for evaluation of cataracts, floaters, flashes of light, or other eye disorders better assessed with dilation.
PLEASE NOTE: THERE IS AN ADDITIONAL CHARGE OF $39.00 THAT WILL NEED TO BE COLLECTED ON DATE OF SERVICE. THE OPTOMAP RETINAL IMAGE IS NOT COVERED BY INSURANCE.

I have read and understand above, and

( ) I want both DILATION and the Optomap Retinal Image; I agree to pay the $39.00 fee today. (RECOMMENDED)
( ) I do not want to be dilated and agree to pay the $39.00 fee for the Optomap Retinal Image.
( ) I decline the Optomap Retinal Image but wish to have my eyes dilated.
( ) I decline both the Optomap Retinal Image and dilation at this time. (NOT RECOMMENDED)

Print Patients Name: ______________________________ Date of birth: ______________

Patient/Guardian Signature: ___________________________ Date: ______________

Parental Consent

I, ______________________, the parent or legal guardian of ______________________
(parent/guardian name please print) *(patient name, please print)*
authorize the dilation of his/her eyes for a routine eye exam and/or necessary medical treatment deemed necessary by qualified medical personnel. This form will remain in effect until revoked in writing by me.

Minor/Patient Name: ______________________________ Date of birth: ______________

Parent/Guardian Signature: ___________________________ Date: ______________

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Patient Consent for Use and Disclosure of Protected Health Information

1. With my consent, **Eye Physicians of Long Beach, a Medical Group, Inc.** may use and disclose **P**rotected **H**ealth **I**nformation (PHI) about me to carry out **T**reatment, **P**ayment, and healthcare **O**perations (TPO). Please refer to **Eye Physicians of Long Beach** Notice of Privacy Practices for a more complete description of such uses and disclosures.

    - I have the right to review the Notice of Privacy Practices prior to signing this consent.
    - Eye Physicians of Long Beach, a Medical Group, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A future revised Notice of Privacy Practices may be obtained by forwarding a written request to Eye Physicians of Long Beach, a Medical Group, Inc. at 2925 Palo Verde Ave., Long Beach, CA 90815.

2. With my consent, **Eye Physicians of Long Beach, a Medical Group, Inc.** may mail, fax, email, call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items, and any call, fax or email pertaining to my clinical care, including laboratory results, prescriptions for medications, prescriptions for glasses and contact lenses, the making of the lenses for the glasses, and any other detail of providing the best possible service to me.

    I have the right to request that **Eye Physicians of Long Beach, a Medical Group, Inc.** restrict how it uses or discloses my **PHI** to carry out **TPO**. However, this office is not required to agree to my requested restrictions; but, if it does, it is bound by this agreement. I hereby consent to the use of my **Protected Health Information** in the manner indicated in items one and two. No further consent is required, and this consent will remain effective until I request otherwise in writing.

_______________________________________ ________________
Signature Date

Financial Responsibilities

It is understood and agreed that I shall notify **Eye Physicians of Long Beach, a Medical Group, Inc.** of any change(s) in my insurance and that I shall be personally responsible for all costs incurred due to any charge(s) in the event that notification is not made. Many insurances, including Medicare, do not pay for refractions. If a refraction (the portion of the exam to determine the glasses prescription) is performed I understand I may be responsible for the cost. I authorize payment of benefits to **Eye Physicians of Long Beach, a Medical Group, Inc**. for medical services rendered. It is understood and agreed that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate that said account then I shall be personally liable for the unpaid balance of the account. In the event of default, I may also be responsible for collection costs, a reasonable rate of interest, and/or reasonable attorney's fees.

_______________________________________ ________________
Signature Date

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PRIVACY NOTICE

Our **Notice of Privacy Practice** describes in more detail how your health information may be used or disclosed, and how you can access your information. I authorize EPLB to provide medical information and pertinent details of my medical history to the below personal representatives/individuals. If your designated personal representatives change, you must contact EPLB in writing to request the change.

Spouse: ____

Children: ____

Siblings: ____

Parent/Guardian: ____

Caregiver/Nursing Home: ____

Other: ____

By signing, I acknowledge that I have read and fully understand this Notice of Privacy Practice.

____ ________________

Patient/Legal Guardian Name Date

____

Patient/Legal Guardian Signature

*A personal representative as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is any family member, friend or individual designated by the patient to whom the patient's health information may be disclosed.

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Medical History

Patient Name ______________________________ Birth Date ____________________

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

Check ☑ Yes boxes only. No need to check ❑ No boxes.

EYES

Loss of Vision	❑ Yes	❑ No
Loss of Side Vision	❑ Yes	❑ No
Distorted Vision or Halos	❑ Yes	❑ No
Fluctuating Vision	❑ Yes	❑ No
Flashes	❑ Yes	❑ No
Floaters	❑ Yes	❑ No
Eye Pain or Soreness	❑ Yes	❑ No
Light Sensitivity	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No
Crossing or Drifting of Eyes	❑ Yes	❑ No
Redness	❑ Yes	❑ No
Discharge	❑ Yes	❑ No
Foreign Body Sensation	❑ Yes	❑ No
Sandy or Gritty Feeling	❑ Yes	❑ No
Dryness	❑ Yes	❑ No
Itching	❑ Yes	❑ No
Burning	❑ Yes	❑ No
Excess Tearing/Watering	❑ Yes	❑ No
Glare	❑ Yes	❑ No
Styes	❑ Yes	❑ No

Other ______________________________

CONSTITUTIONAL

Fever	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No
Weight Gain	❑ Yes	❑ No

SKIN

Rashes or Color Changes	❑ Yes	❑ No
Itching or Dryness	❑ Yes	❑ No
Hair or Nail Changes	❑ Yes	❑ No

EARS, NOSE, MOUTH & THROAT

Hearing Difficulty	❑ Yes	❑ No
Ringing	❑ Yes	❑ No
Vertigo	❑ Yes	❑ No
Sinus Congestion	❑ Yes	❑ No
Runny Nose	❑ Yes	❑ No
Post-Nasal Drip	❑ Yes	❑ No
Nosebleeds	❑ Yes	❑ No
Dry Throat/Mouth	❑ Yes	❑ No
Hoarseness	❑ Yes	❑ No
Jaw Claudication	❑ Yes	❑ No

CARDIOVASCULAR

Chest Pain	❑ Yes	❑ No
Palpitations	❑ Yes	❑ No

Other ______________________________

RESPIRATORY

Cough	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No

GASTROINTESTINAL

Swallowing Difficulty	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No
Diarrhea	❑ Yes	❑ No
Constipation	❑ Yes	❑ No
Nausea	❑ Yes	❑ No

GENITO-URINARY

Urinary Frequency	❑ Yes	❑ No
Urinary Pain or Blood	❑ Yes	❑ No
Males		
Discharge	❑ Yes	❑ No
Lesions or Masses	❑ Yes	❑ No
Females		
Currently Pregnant	❑ Yes	❑ No
Breast Masses	❑ Yes	❑ No
Breast Discharge	❑ Yes	❑ No
Vaginal Bleeding/Discharge	❑ Yes	❑ No

MUSCULOSKELETAL

Joint Pain	❑ Yes	❑ No
Joint Swelling	❑ Yes	❑ No
Redness	❑ Yes	❑ No
Muscle Pain	❑ Yes	❑ No
Muscle Cramps	❑ Yes	❑ No

NEUROLOGICAL

Headaches	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Tingling	❑ Yes	❑ No
Weakness	❑ Yes	❑ No
Paralysis	❑ Yes	❑ No
Fainting	❑ Yes	❑ No
Blackouts	❑ Yes	❑ No
Slurred Speech	❑ Yes	❑ No

PSYCHIATRIC

Anxiety	❑ Yes	❑ No
Depression	❑ Yes	❑ No

Other ______________________________

ENDOCRINE

Heat Intolerance	❑ Yes	❑ No
Cold Intolerance	❑ Yes	❑ No
Excessive Thirst	❑ Yes	❑ No
Excessive Hunger	❑ Yes	❑ No

HEMATOLOGICAL

Easy Bruising	❑ Yes	❑ No
Easy Bleeding	❑ Yes	❑ No
Blood Transfusions	❑ Yes	❑ No
Swollen Lymph Nodes	❑ Yes	❑ No

ALLERGY

Seasonal Allergies	❑ Yes	❑ No

Additional Notes/Comments:

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Medical Information

Patient's Name: ______________________________ Birth Date: ____/____/____

Do you wear glasses or contact lenses? ❑ Yes ❑ No If Yes, for how long? ______________________

Please ✓ if any of the following apply to you and the date it first occurred:

MEDICAL PROBLEMS

Condition	Please ✓	Date
Alzheimers	❑ Yes ❑ No	________
Arthritis	❑ Yes ❑ No	________
Asthma/COPD/Bronchitis	❑ Yes ❑ No	________
Cancer – type ___________	❑ Yes ❑ No	________
Diabetes – type ___________	❑ Yes ❑ No	________
High blood pressure	❑ Yes ❑ No	________
Hepatitis/Jaundice	❑ Yes ❑ No	________
Heart Disease	❑ Yes ❑ No	________
Head Injury	❑ Yes ❑ No	________
HIV positive/AIDS	❑ Yes ❑ No	________
Kidney Disease	❑ Yes ❑ No	________
Lupus	❑ Yes ❑ No	________
Migraine Headaches	❑ Yes ❑ No	________
Rheumatic Fever	❑ Yes ❑ No	________
Sarcoidosis	❑ Yes ❑ No	________
Seizures	❑ Yes ❑ No	________
Stroke	❑ Yes ❑ No	________
Syphilis / Gonorrhea	❑ Yes ❑ No	________
Thyroid Disease	❑ Yes ❑ No	________
Tuberculosis	❑ Yes ❑ No	________

Other Medical Problems (Please List)

____
____
____
____
____

SURGICAL HISTORY

Have you had **general** surgery? ❑ Yes ❑ No
Please list:

Surgery	Date	Surgeon/Hospital

Have you had **eye** surgery? ❑ Yes ❑ No
Please list (including laser and lid surgery):

Surgery	Date	Surgeon/Hospital

MEDICATIONS *(Please List)*

Name	Dosage

Are you allergic to any medications, iodine, latex or anesthesia?
❑ Yes ❑ No If *yes*, please list below:

____

Do you require antibiotics prior to dental work or surgery?
❑ Yes ❑ No

FAMILY MEDICAL PROBLEMS

Do any family members have:	Please ✓	Relative
Glaucoma	❑ Yes ❑ No	________
Macular Degeneration	❑ Yes ❑ No	________
Diabetes	❑ Yes ❑ No	________
Retinal Detachment	❑ Yes ❑ No	________
Cataracts	❑ Yes ❑ No	________
Amblyopia/Strabismus	❑ Yes ❑ No	________

Other (list): ______________________________

SOCIAL HISTORY

Question	
Are you pregnant?	❑ Yes ❑ No
Do you smoke?	❑ Yes ❑ No
Do you drink alcohol?	❑ Yes ❑ No
Do you drink caffeine?	❑ Yes ❑ No
Do you use illegal drugs?	❑ Yes ❑ No

This is to certify, I, the undersigned, consent to examination and treatment. This information and any photographs may be used for science and educational purposes. I hereby authorize Eye Physicians of Long Beach to release information to my insurance carrier, employer, referring physician, or other physician regarding my treatment and/or illness. I transfer assignment of all my insurance benefits to Eye Physicians of Long Beach for services, treatment, supplies or surgeries provided by physicians or staff. I understand that I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Patient Signature ______________________________ **Date** ____________