PUPILA
Family Eye & Ear Care

WELCOME TO PUPILA FAMILY EYECARE!

HOW DID YOU HEAR ABOUT US?

TODAY'S DATE (MM/DD/YYYY)*

FIRST NAME*

LAST NAME*

DOB (MM/DD/YYYY)*

SSN#*

STREET ADDRESS*

ADDRESS LINE 2

CITY*

STATE / PROVINCE / REGION*

ZIP / POSTAL CODE*

COUNTRY*

HOME PHONE

CELL PHONE*

EMAIL ADDRESS*

EMPLOYER*

OCCUPATION

MEDICAL INSURANCE

INSURANCE NAME

- ☐ Aetna
- ☐ Ambetter
- ☐ Cigna
- ☐ Blue Cross Blue Shield of Texas
- ☐ Humana
- ☐ United Healthcare
- ☐ Medicare
- ☐ Medicaid
- ☐ Other:
- ☐ None

INSURANCE ID #

INSURANCE GROUP #

VISION INSURANCE

INSURANCE NAME

- ☐ VSP
- ☐ Eyemed
- ☐ Spectera
- ☐ Superior Vision
- ☐ Davis
- ☐ None
- ☐ Other:

DEMOGRAPHICS

RACE

- ☐ White
- ☐ Asian
- ☐ African-American
- ☐ Decline to Answer

ETHNICITY

- ☐ Non-Hispanic or Latino
- ☐ Unknown
- ☐ Hispanic or Latino
- ☐ Decline to Answer

LAST PRIMARY CARE VISIT

PRIMARY CARE DOCTOR

LAST EYE EXAM

PREVIOUS EYE DOCTOR

LIST ANY PREVIOUS SURGERIES WITH DATES

ARE YOU PREGNANT OR BREASTFEEDING? ☐ YES ☐ NO

HOBBIES AND SPORTS YOU ENJOY

HOW MANY HOURS PER DAY DO YOU USE THE COMPUTER?

DO YOU WEAR EYEGLASSES? ☐ YES ☐ NO

DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

ARE YOU INTERESTED IN CONTACT LENSES? ☐ YES ☐ NO

ARE YOU INTERESTED IN REFRACTIVE SURGERY? ☐ YES ☐ NO

DO YOU PERFORM FINE OR CLOSE-UP WORK? ☐ YES ☐ NO

ARE YOU OUTDOORS ALL OR PART OF THE TIME? ☐ ALL OF THE TIME ☐ PART OF THE TIME

DO YOU HAVE TROUBLE READING SIGNS WHILE DRIVING? ☐ YES ☐ NO ☐ SOMETIMES

ARE YOU BOTHERED BY GLARE FROM ☐ Overhead lighting ☐ A computer screen ☐ Oncoming headlights at night

ARE YOU SENSITIVE IN BRIGHT SUNLIGHT? ☐ YES ☐ NO

LIST ANY MEDICAL AND EYE CONDITIONS YOU MAY HAVE

LIST MEDICATIONS YOU ARE TAKING

LIST ANY FAMILY MEDICAL AND EYE CONDITIONS

LIST ANY ALLERGIES THAT YOU HAVE

SOCIAL HISTORY

ARE YOU A DRUG USER? ☐ YES ☐ NO

ARE YOU A: ☐ Non-drinker ☐ Social Drinker

TOBACCO USE

☐ Heavy Tobacco Smoker ☐ Former Smoker

☐ Light Tobacco Smoker ☐ Never a smoker

DILATED FUNDUS EXAM CONSENT FORM

In order to provide the most comprehensive exam possible we request that all of our patients have a retinal imaging. At least 80% of the retina cannot be viewed without dilation. The purpose is to enhance the detection of any ocular diseases such as cataracts, glaucoma, retinal disease, malignant growth, and retinal detachment; all of which can lead to vision loss. In addition, some systemic conditions such as diabetes and hypertension can cause changes in the health of the eye and can be detected by retinal imaging.

- You leave the office with vision intact, rather than with light-sensitivity and blur.
- Creates permanent record.
- Allows for future comparisons. We can compare this year's image to next year's image - side by side.
- Can be reviewed by other doctors, if necessary.
- It allows for an enlarged image to see a more detailed view of the retina.
- Early detection of life-threatening diseases like cancer, stroke, and cardiovascular disease.
- Facilitates early protection from vision impairment or blindness.

THE COST FOR THIS PROCEDURE IS $39.00. If you have certain medical conditions, your insurance may cover all or a portion of this procedure.

YES, I ACCEPT THE STATE-OF-THE ART PROCEDURE RECOMMENDED BY MY DOCTOR. ☐ YES ☐ NO

I AM NOT SURE ABOUT THE STATE-OF-THE-ART PROCEDURE RECOMMENDED BY MY DOCTOR. SHOULD YOU HAVE ANY FURTHER QUESTIONS, PLEASE ASK STAFF OR DOCTOR FOR EXPLANATION. ☐ YES ☐ NO

PRINT NAME TO ACCEPT

HIPAA

Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent/Limited Authorization & Release Form for Pupila Family Eyecare.

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

☐ First name only ☐ Proper Surname ☐ Other:

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION

PLEASE CHECK YOUR PREFERRED METHOD OF COMMUNICATION

☐ Home Phone ☐ Email ☐ Cell Phone ☐ Text Message

CAN WE LEAVE AUTOMATED APPOINTMENT REMINDERS ON YOUR HOME OR CELL PHONE?

☐ YES ☐ NO

CAN WE LEAVE MESSAGES LETTING YOU KNOW YOUR GLASSES AND CONTACTS ARE READY?

☐ YES ☐ NO

PRINT PATIENT FULL NAME

FINANCIAL POLICY

The doctor and staff at Pupila Family Eyecare are pleased that you have chosen us for your eyecare needs. Please review our financial policy and acknowledge it with your signature below.

1. Payment for professional services (eye examinations, specialty testing, medical visits) is due the day services are provided. Payment for eyeglasses and contact lenses is due in full the day materials are ordered. For your convenience, we accept cash, debit cards, Visa, Mastercard, Discover, and Care Credit.
2. Eyeglasses are customized products and all optical sales are final.
3. Payments for copays, deductibles, and items known not to be covered by your insurance is due at the time of your visit. You are ultimately responsible for all charges for which your insurance company denies payment when we receive your Explanation of Benefits statement from them. Payment is due within 30 days after having been notified by your insurance and/or providers.

4. In the event that we do not participate with your Vision Plan or Medical Insurance, payment is due in full when services are rendered. We will provide you with an itemized receipt so that you may file with your carrier for reimbursement.
5. Both established and new contact lens wearers are subject to a contact lens medical evaluation and fitting fee. This fee is due at the date of the initial evaluation.
6. For those with Flexible Spending Accounts, payment in full is due for services rendered and materials ordered. An itemized statement that can be submitted to your insurance company for reimbursement will be given to you at the time of your visit.
7. If payment from your insurance company has not been received in 60 days, you will be responsible for paying your account balance in full.
8. Finance charges at the rate of 1.5% month (18% APR) will accrue on all outstanding balances.
9. In some families, the question of who is responsible for a child's bill is uncertain. Since we are not party to any separation agreement or court order, this is strictly a matter between parents. We must insist, therefore, that the parent who requests evaluation and treatment for the child will be responsible for all fees incurred.
10. If our office pursues legal action to collect unpaid charges, you will be billed the cost of attorney fees, courts costs, and collection fees in addition to any unpaid balances.

I have read and understand the above information and agree to the terms set forth in this agreement. I understand that if I fail to make any payments my account may be turned over to a collection agency.

PRINT NAME TO ACCEPT

CONTACT LENS PRESCRIPTION SIGNED ACKNOWLEDGMENT FORM

The Centers for Disease Control and Prevention (CDC) makes clear, "Contact lenses can provide many benefits, but they are not risk-free—especially if contact lens wearers don't practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor. However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment."

The CDC recommends the following for contact lens wearers:

- ✓ Schedule a visit with your eye doctor at least once a year. ☒ Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision. ☒ Understand that eye infections that go untreated can lead to eye damage or even blindness.

The Food and Drug Administration (FDA) indicates:

- ✓ "To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It's safer to be re-checked by your eye care professional." Symptoms of Eye Infection include: • Irritated, red eyes • Worsening pain in or around the eyes—even after contact lens removal • Light sensitivity • Sudden blurry vision • Unusually watery eyes or discharge

Sign below to acknowledge that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting.

SIGNATURE

https://www.cdc.gov/contactlenses/pdf/Eyewise-doctor-8x11.pdf
https://www.fda.gov/medical-devices/contact-lenses/buying-contact-lenses
https://www.cdc.gov/contactlenses/germs-infections.html

DRY EYE EVALUATION

DO YOU EXPERIENCE EYE DISCOMFORT?

a. During a typical day in the past month, how often did your eyes feel discomfort?

☐ Never ☐ Frequently
☐ Rarely ☐ Constantly
☐ Sometimes

b. When your eyes felt discomfort, how intense was this feeling of discomfort at the end of the day, within two hours of going to bed?

☐ Never ☐ Frequently
☐ Rarely ☐ Constantly
☐ Sometimes

DO YOU EXPERIENCE EYE DRYNESS?

a. During a typical day in the past month, how often did your eyes feel dry?

☐ Never ☐ Frequently
☐ Rarely ☐ Constantly
☐ Sometimes

b. When your eyes felt dry, how intense was this feeling of dryness at the end of the day, within two hours of going to bed?

☐ Never ☐ Frequently
☐ Rarely ☐ Constantly
☐ Sometimes

DO YOU HAVE WATERY EYES?

During a typical day in the past month, how often did your eyes look or feel excessively watery?

☐ Never ☐ Frequently
☐ Rarely ☐ Constantly
☐ Sometimes

MYOPIA CONTROL/MANAGEMENT

To find out your child's risk for myopia, take our short quiz. With only a few questions, you will know your child's risk level for progressive myopia and what you can do to help them. Together, we can fight the pandemic of near-sightedness/myopia that is associated with several sight-threatening eye diseases.

Is your child myopic (Needs glasses or contact lenses to see clearly at a distance)?

- ☐ Yes
- ☐ Unsure
- ☐ No
- ☐ N/A

Is an immediate family member (father, mother or sibling) myopic? (select YES even if that family member has had LASIK or another refractive surgery procedure for myopia)

- ☐ Yes
- ☐ Unsure
- ☐ No

Does your child spend less than 2 hours/day outdoors, including school recess/breaks?

- ☐ Yes
- ☐ Unsure
- ☐ No

Does your child spend more than 2 hours/day doing near work (reading, using an electronic device and/computer, etc.)?

- ☐ Yes
- ☐ Unsure
- ☐ No

RECEIVING EYE EXAMS DURING THE COVID-19 PANDEMIC

You have come to our office today for a routine Comprehensive Exam, that will be done during the COVID-19 pandemic.

Please be advised of the following.

While our office compiles with the State Health Department and the centers for disease control and prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and to the best of their knowledge, have not been exposed to the virus. However since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge. To reduce the risk of spreading COVID-19, we have asked you a few "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? ☐ YES ☐ NO

ARE YOU SHOWING ANY SYMPTOMS OF COVID-19? ☐ YES ☐ NO ☐ OTHER:

FULL NAME IN PRINT