

WELCOME TO TARGET OPTICAL/ABIGAIL DAVID OPTOMETRY!

Last Name _____ First Name _____ MI _____ Prefer to be called _____
 Today's Date ____/____/____ Your Birth Date ____/____/____ Cell Phone Number _____
 Address _____ City _____ State _____ Zip _____
 Email Address _____
 Employer _____ Occupation _____
 Parent or Guardian (if under 18) _____
 Name of Insured (if other than patient) _____

MEDICAL AND OCULAR HISTORY

What brings you in today? _____
 Any vision concerns or changes? _____
 About how old are your glasses? _____ About how long ago was your last eye exam? _____
 Where was your last eye exam? _____

Please check any/all of these conditions that apply to yourself or your parents.

Condition	Self	Mother	Father	Explain
Headaches/Migraines				
Anxiety/Depression				
Are you pregnant?				
Thyroid Dysfunction				
Heart Disease				
Hypertension				
Diabetes				Type 1 _____ Type 2 _____
Cancer				
Asthma				
Glaucoma				
Eye Surgery				What kind? _____ When? _____
Macular Degeneration				
Cataracts				

Are you currently using any eye drops (either prescription or over-the-counter?) If yes, please list:

What medications or over-the-counter drugs do you take? _____

Do you have any medication allergies? _____
 Seasonal/environmental allergies? _____

How many hours do you spend looking at a computer or device per day? _____

Please review the HIPAA Privacy Notice/Authorization on the back of this form, then sign and date below.

Signature: _____ **Date:** _____

CONTACT LENS PATIENTS ONLY:

What brand of contacts do you wear? _____ How often do you sleep in them? _____

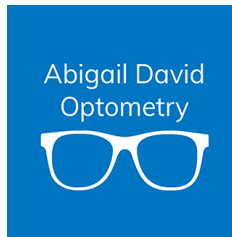
Regarding your current contacts, what do you:

Like: Clarity of vision ____ Comfort ____ Other _____

Dislike: Clarity of vision ____ Comfort ____ Dryness ____ Itchiness ____ Other _____

Please review the Contact Lens Prescription Release Agreement and Consent on the back of this form, then sign and date below.

Signature: _____ **Date:** _____



ABIGAIL DAVID OPTOMETRY
HIPAA PRIVACY NOTICE /AUTHORIZATION
(Updated January 6, 2021)

I can be assured that Abigail David Optometry will not sell my personal health information to any third party. I understand that Abigail David Optometry may use and disclose necessary personal information (for example, name, address, subscriber identification number, eye exam information and/or type of products provided) to perform its administrative duties, provide me with eyecare service and products, process my vision benefits claims and communicate with me regarding vision care services. Specifically, I authorize Abigail David Optometry to use and disclose my individually identifiable health information as follows:

1. To Target Optical, so that it can:

- Submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products I receive.
- Keep an updated patient database and provide me with appointment reminders and information about Target Optical products and services.

2. To any other medical providers (such as eye surgeons or other vision specialists) to whom Dr. David and/or her associates might refer me to for additional treatment.

I understand that this authorization is voluntary. I also understand that I may revoke this authorization at any time and am entitled to a copy of this disclosure, and that this authorization expires in four years.

CONTACT LENS PRESCRIPTION RELEASE AGREEMENT AND CONSENT:

We are happy to provide you with your prescription for contact lenses upon completion of your contact lens fitting service. With your signature on the front of this form, you acknowledge:

- You have been informed of the need to schedule and attend follow-up appointments with your optometrist and you will comply with the wearing schedule and cleaning method that your optometrist has prescribed for you.
- You understand that you should notify your optometrist immediately if you experience any symptoms such as unusual redness, irritation, or blurred vision while wearing your contacts, and failure to do so may result in injury to your eyes and damage to your vision.
- You will receive a copy of your contact lens prescription at the completion of your contact lens fitting service.
- You acknowledge that electronic delivery (via email) of your prescription also satisfies the requirements of this notification process, and that we may email your finalized prescription if trial contacts are given to you.