Radiant
OPTOMETRY

SEE CLEARLY, LIVE FREELY

PATIENT INFORMATION

Name (Last, First) _____ DOB:_____/_____/_____ Age: _____ ☐M ☐F Date: _____/_____/_____
Address _____ City:_____ State: _____ Zip Code:_____
Primary Phone #: (_____) _____-_____ Secondary Phone #: (_____) _____-_____ Email: _____

INSURANCE

Person responsible for account (Last, First) _____ Relation to Patient: _____
Insurance Name: _____ Member ID: _____ Member's DOB: ___/____/_____ Social Security: _____

EYE HEALTH HISTORY

Last Eye Exam: _____ Year(s) Name of Doctor/Office:_____
Any eye diseases, injuries, or surgeries in the past? ☐Yes ☐No ***If Yes***, what is it and when it was diagnosed? _____
Do you wear glasses currently? ☐Yes ☐No ***If Yes***, how often? ☐All the time ☐Occasionally ☐For Distance ☐For Near ☐Both
Do you wear contacts currently? ☐Yes ☐No ***If Yes***, what brand? _____ ☐Dailies ☐Bi-weekly ☐Monthly
Any problems with your contacts? ☐Yes ☐No ***If Yes,*** what is it? ☐Dryness ☐Rips Easily ☐Uncomfortable by the end of the day
Are you interested in vision correction through Contact Lens (Ortho-K)? ☐Yes ☐No

Please check all symptoms you are currently experiencing:

☐Blurry Vision-Distance	☐Double Vision	☐Watery	☐Headaches	☐Dryness/Sandy	☐Flashes	☐Other_____
☐Blurry Vision-Near	☐Itchy Eyes	☐Eyestrain	☐Discharge	☐Light Sensitivity	☐Floaters	

MEDICAL HEALTH HISTORY

Name of Primary Care Physician: _____ Date of Last Physical Exam: _____

Do **YOU** or any **BLOOD RELATIVES** have any of the following conditions?

	Self	Relatives		Self	Relatives		Self	Relatives		Self	Relatives
AIDS/HIV	☐	☐	Diabetes	☐	☐	Lupus	☐	☐	Stroke	☐	☐
Arthritis	☐	☐	Emphysema	☐	☐	Migraines	☐	☐	Thyroid	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐	Retinal Disease	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Shingles	☐	☐	Other_____	☐	☐

Please list medications you are currently taking, including eye drops:
MEDICATIONS
☐Metformin ☐Glipizide ☐Insulin ☐Lisinopril ☐Atenolol
☐Atorvastatin ☐Simvastatin ☐Gabapentin ☐Amlodipine ☐Levothyroxine
☐Other: _____

Please list your allergies to medications or other substances:
ALLERGIES
☐Penicillin ☐Sulfa Drugs
☐Other: _____

SOCIAL HISTORY

Do you play any sports? ☐No ☐Yes _____ Do you have any hobbies? ☐No ☐Yes _____
Do you (check all that apply) ☐Smoke ☐Drink ☐Use Recreational Drugs Hours spent on ____☐TV _____☐Computer _____☐Video Games

ASSIGNMENT AND RELEASE

I certify that, I and/or my dependents (s), have insurance coverage with _____(name of insurance) and assign directly to Radiant Optometry all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature:_____ Date: _____
Patient | Parent | Guardian | Personal Representative

Print Name: _____ Date: _____
Patient | Parent | Guardian | Personal Representative

RETURN POLICIES

PROFESSIONAL SERVICES
Professional fees (examination, refraction, contact lens fitting/evaluation, or any services performed "by the doctor") are **NOT** refundable

FRAMES
Select frames have a limited, one-year manufacturer's defect warranty. Any alterations or gluing of frames will void the warranty. Please note, due to insurance regulations, frame exchanges may not be allowed. Please be aware, if the lenses are already made with the frame you chose, choosing a different frame will mean you need to pay to have the lenses be remade into the new frame. Medi-Cal frames are **NOT** under warranty.

SUNGLASSES
All **non-prescription** sunglasses may be exchanged within **14** days of purchase. They must be returned in new condition and with the original case. Full credit will be applied to the patient's account to be used toward future purchases. Unfortunately, **NO** refunds can be issued.

LENSES
All lenses are custom made. Therefore, we **CANNOT** accept any cancellation or offer any refund once the order for the lenses are placed.

If progressive lenses have been ordered and you cannot adapt to them, we will have them remade to single vision, bifocal or trifocal lenses at no additional costs (1 time only). However, you will **NOT** get a refund due to the expenses incurred by the laboratory.

Within **30** days, if you are not satisfied with your prescription or lenses, please call the office and speak with an optician to help you with this matter.

CONTACT LENSES
Unopened, undamaged, unmarked, and unexpired contact lens boxes may be exchanged or returned for full credit toward the purchase of contact lenses or eyewear within **30** days from the date of purchase.

PROMOTIONAL PACKAGE
- Professional fees (examination, refraction, contact lens fitting/ evaluation, or any services performed "by the doctor") are **NOT** refundable.
- Frames are **NOT** refundable or exchangeable unless it is a manufacturer defect.
- Lenses can be remade once if the prescription is not correct (non-adaptation issue). You will **NOT** get a refund due to the expenses incurred by the laboratory.

We offer unlimited cleanings and adjustments for any glasses purchased in our office at no extra charge

My signature below attests that I have received, read, and agree to these return policy terms:

Signature:_____ Date:_____
Patient | Parent | Guardian | Personal Representative

. **HIPAA**
CONSENT OF DISCLOSURE

I hereby give consent to Radiant Optometry to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your own behalf, and delivered to the address on the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request a restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our posted privacy policy provides more detailed information about the usage and disclosures of your protected health care information. You have the right to review our posted privacy policy before you sign this consent.

We reserve the right to amend the terms of our posted privacy policy. You may obtain a copy of this current policy at our office any time or by calling **(562) 867-4716.**

CONSENT	CANCELLATION
Date: _____	Date: _____
Print Name of Patient: _____	I, _____ hereby void the consent given above
Signature of patient: _____	Signature of patient: _____
Patient's Representative: _____	Patient's Representative: _____
Relationship to Patient: _____	Relationship to Patient: _____
	Your cancellation will be effective upon receipt at Radiant Optometry