Office Visit

PLEASE PRINT (write as legible as possible and **fill out every question**)

Name: _____ Date of Birth: _____/_____/_____ Date:_____

Address: _____

City: _____ State: _____ Zip Code: _____Phone Number: _____

E-mail Address: _____Occupation: _____ Employer: _____

Medical Insurance _____ Member ID: _____

First notice: Date: _____ Time: _____ PM

Right eye Left Eye Both Eyes

Please check all that apply:

_____Red
_____Swollen
_____Pain
_____Light Sensitivity
_____Watery
_____Lashes Sticky
_____Itchy
_____Decreased Vision
_____Discharge (Describe)
_____Other (Describe)

1. Are you a contact Lens Wear? NO (**If no skip to question 7**)
2. What type of lenses do you wear? MONTHLY
3. When did you last wear your contacts? _____
4. How old are your lenses? _____
5. Do you sleep in you lenses? NO
   If yes, how long do you wear them before removing? _____
6. What solution do you use? _____
7. Have you suffered any eye injury? NO please explain:_____
8. Are you using any medication presently in your eyes? _____
9. Are there any additional comment you feel will assist the Doctor in treating your condition?
   _____

NOTICE OF PRIVACY PRACTICES

I have read and understand Clearly Eyecare's Notice of Privacy Practices Form. I also understand that I have 30 days to return to the clinic with any concerns regarding my prescription at no charge. Any visits after the 30-day period may be subject to an additional examination fee due to possible changes in vision.

Patient Signature: _____ Date: _____

COVID-19 PANDEMIC ESSENTIAL EYE EXAM AND TREATMENT CONSENT FORM

Patient Name: _____ **DOB**: _____ **Date**: _____

Please read and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all these questions, you will be asked to postpone or reschedule your visit to a later date.

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, and loss of smell/taste or other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of the state or country in the last 30 days.

I understand that Clearly Eyecare, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Clearly Eyecare or any of its doctors and staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge DLV and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

_____ _____ _____

PRINT LEGAL NAME SIGNATURE DATE