WELCOME TO OUR OFFICE

LAST NAME:_____

FIRST NAME:_____MIDDLE INITIAL:_____

NICKNAME:_____ MR MRS MISS DR MARITAL STATUS: S M D W DP

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____x_____

CELL PH: ☐same as home _____ EMAIL:_____

PATIENT DATE OF BIRTH:_____ PATIENT SS#:_____-_____-_____

PATIENT EMPLOYER / SCHOOL:_____ F.T. STUDENT: Y/N

PATIENT OCCUPATION / GRADE:_____

FAMILY PHYSICIAN (PCP): _____DR.'S PH#_____

LAST MEDICAL EXAM:_____

FORMER EYECARE PROFESSIONAL: _____LAST EXAM:_____

DO YOU WEAR: ☐GLASSES ☐SUNGLASSES ☐CONTACT LENSES – TYPE:_____

HAS ANY MEMBER OF YOUR FAMILY BEEN OUR PATIENT?_____

ARE YOU INTERESTED IN REFRACTIVE SURGERY FOR VISION CORRECTION? Y / N

WHO MAY WE THANK FOR REFERING YOU TO US?_____

FINANCIALLY RESPONSIBLE / INSURED: LAST NAME:_____

FIRST NAME:_____MIDDLE INITIAL:_____ DOB:_____

RELATIONSHIP TO PATIENT: _____ LAST 4 SS#:_____

NAME OF VISION INSURANCE:_____ ID #:_____

NAME OF MEDICAL INSURANCE:_____ID #:_____

PLEASE NOTE: WE BILL INSURANCE COMPANIES AS A COURTESY. INSURANCE AUTHORIZATIONS MAY NOT BE A GUARANTEE OF PAYMENT. I HERBY AUTHORIZE PAYMENT DIRECTLY TO DR. KRISTOPHER SKROMME FOR ANY INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME, FOR SERVICES AND MATERIALS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES AT TIME OF SERVICE THAT ARE NOT COVERED BY MY INSURANCE.

LONG TIME AUTHORIZATION / FINANCIAL RESPONSIBILITY / "SIGNATURE ON FILE"

PATIENT /GUARDIAN SIGNATURE:_____ DATE:_____

PRINT NAME :_____ RELATIONSHIP TO PATIENT:_____

(PLEASE TURN FORM OVER)

TWO TREES OPTOMETRY - KRISTOPHER R. SKROMME, OD
801 S. VICTORIA AV, SUITE 206 - VENTURA, CA. 93003
RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT FORM

Patient Name:_____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses in detail. You are free to refer to this notice at any time before you sign this form. As described in **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices.** Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at our office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices,** we are not obliged to agree to theses suggested restrictions. If we agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purpose of treatment, payment, and healthcare operations. I acknowledge that I have received the **Notice of Privacy Practices from Dr. Skromme.**

_____ _____

Patient / Parent-Guardian Signature Date

_____ _____

Relationship to Patient Print Name

Source of Authority: _____

TWO TREES OPTOMETRY - KRISTOPHER R. SKROMME, OD
801 S. VICTORIA AV, SUITE 206 - VENTURA, CA. 93003

Patient Health History

Name: DOB: Date:

Briefly state any visual problems: _____

Do you wear glasses? ☐NO ☐YES
Do you wear contacts? ☐NO ☐YES Are you interested in wearing contact lenses? ☐NO ☐YES

Patient Eye History
Indicate if any of these conditions apply to you:

☐Cataract ☐Macular Degeneration ☐Glaucoma ☐Retinal Detachment ☐Lazy Eye ☐Drooping Lid ☐Other_____

List any eye injuries and/or eye surgeries (**ie. Cataract surgery, LASIK, ect.**) please include dates and which eye:_____

Indicate if you are currently experiencing any of these symptoms:

☐Redness	☐Tearing/Watering	☐Double Vision	☐Foreign Body Sensation
☐Floaters	☐Dryness	☐Glare/Light Sensitivity	☐Eye pain/soreness
☐Flashes	☐Itching	☐Mucous Discharge	☐Loss of Vision

Further explanation, if needed:_____

Patient Medical History
Indicate if any of these conditions apply to you:

☐Diabetes	☐Stroke	☐Allergies	☐Depression	☐Sinus Congestion	☐Vascular Disease
☐High Blood Pressure	☐Thyroid	☐Seizures	☐Bronchitis	☐Migraines	☐HIV/AIDS
☐Cholesterol	☐Cancer	☐Ashtma	☐Hepatitis	☐Anemia	☐Other _____

Further explanation, if needed:_____

List any medications you take (including oral contraceptives, asprin, over the counter medications, and home remedies)

Do you have any allergies to medications ☐No ☐Yes If yes, explain:_____

Family History
Indicate any family history (blood relative) of the following conditions, and their relationship to you:

☐Cancer_____ ☐ Cataract_____
☐Retinal Detachment_____ ☐Diabetes_____
☐Glaucoma_____ ☐High Blood Pressure_____
☐Macular Degeneration_____ ☐Other_____

Patient Social History
Do you use tobacco products? ☐No ☐Yes If Yes, type:_____
Do you drink alcohol? ☐No ☐Yes If Yes, type:_____
Do you illegal drugs? ☐No ☐Yes If Yes, type:_____
Is there anything private you would like to speak with the doctor about? ☐No ☐Yes
Women Are you pregnant? ☐No ☐Yes Are you breastfeeding? ☐No ☐Yes

Please sign below to acknowledge that this form is correct.

Signature: _____

TWO TREES OPTOMETRY - KRISTOPHER R. SKROMME, OD

TREATMENT CONSENT FORM

RETINAL EXAM

Dr. Skromme recommends that you have your eyes dilated and perform a retinal photo screening. The following groups are in greatest need:

- Diabetics
- Age 50 or older
- Nearsighted (myopic) people with a strong prescription
- Anyone with a history (self or family) of eye disease such as glaucoma, macular degeneration, retinal conditions, and headaches.
- Anyone experiencing symptoms of loss of vision, flashes of light or floaters

Dilation will increase your light sensitivity and decrease your close vision for 2-3 hours. Since everyone is different, the effects of the drops could last as long as 5 hours. Dilation is at no cost to you.

Retinal photo screenings is a more advanced way of checking the health of your eyes. It will establish a base line photo which can be used to compare future subsequent photos. Retinal photos are $39.00 and are not covered by insurance.

Dilation drops are not recommended for women who are pregnant or nursing.

Please indicate below if you would like to have your eyes dilated and/or perform the retinal image screening.

Dilation:	Retinal Photos:
_____ YES	_____YES
_____ NO	_____ NO

CONTACT LENS EVALUATION & FITTING

This portion is for someone interested in wearing, or currently wearing contact lenses. A contact lens is a medical device and requires a different evaluation than your eyeglasses. A contact lens evaluation must be done every year with the doctor to order contact lenses. Contact lens fees may vary from $79-$145. Ask us if your insurance provides any discounts towards these fees.

_____Yes, I would like a contact lens fitting
_____No, I am not interested in contact lenses.

Patient/ Guardian Signature_____ Date:_____