Patient Update Form

Updated: August 10, 2015

Please complete this form and update us on **any changes** that you may have. Please print. Thank you.		
Today's Date		
Patient's Name (Last, First, MI)		
Patient's Date of Birth		
Patient's Phone #		
Patient's Address		
Patient's Height and Weight (voluntary)	Feet Inches	Pounds
Please list any new **current medications**, including eye drops and non-prescription medications, in the space below		
Please list any changes on **allergies to medications or foods, and seasonal allergies** in the space below.		
Please list dates and type of any new surgery, including **eye surgery**, in the space below		
Please indicate **any medical changes since the last visit**		

☐ No medical changes since last visit

Signature of Patient or Legal Guardian____

Beach Eyecare Optometry 5531 E Stearns Street Suite A.
Long Beach, CA 90815 Tel: (562) 596-3838. Fax: (562) 596-3835

PRIVATE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

Please check one of the following:

○ Insurance: I hereby authorize and direct payment of my medical and/or vision benefits to Beach Eyecare Optometry for any services furnished to me by the doctors. I authorize the doctors to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical and/or vision services to third party payers and/or health practitioners. In the event that my health plan determines a service to be "not covered," I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed. Copays are due at the time of service.

○ Private Pay: I authorize the doctors to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical and/or vision services to other health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents, including any fees for collection services needed.

Signature of patient:____Date:______________

Parent/guardian signature (if minor):____

PUPILLARY DILATION CONSENT

Our office routinely dilates every patient to achieve the most comprehensive evaluation of the health of your eyes. Whether pupil dilation is necessary for every eye exam depends on the reason for your eye exam, your overall health and your risk of eye diseases.

Dilating the pupils may cause temporary blurring of your vision. We advise that you exercise caution in operating any equipment or machinery, including driving, until the effects have worn off.

Please check one of the following:

☐ I would like my eyes dilated today if the doctor believes it is necessary

☐ I do not want my eyes dilated (see below)

In refusing to have my eyes dilated, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

Signature of patient:____Date:_____________

Parent/guardian signature (if minor):____

Bunthay C. Tan O.D. & Tieng Tan O.D.
5531 E. Stearns Street Suite A
Long Beach, CA 90815
(562) 596-3838
eyecontact@beacheyecareoptometry.com

We are proud to introduce the latest in retinal imaging, the Optomap. It is painless, quick and the doctor's preferred method at looking at the health of your eye. This instrument will enhance our ability to detect and monitor retinal defects associated with common systemic diseases such as hypertension, diabetes, high cholesterol, and thyroid problems. Through this digital imaging of the retina we can observe early changes in the eye relating to glaucoma, cataracts, and macular degeneration. This technology is now our new standard of care.

There is a discounted price of $25 to perform this procedure.

Please check one of the following:

☐ Yes, I would like this new procedure. ☐ I would like to discuss with the doctor.

Print Name: ____ Date: ____________________

Signature: ____

This technology can be used without dilation, and will be a permanent part of your medical records. We are happy to email you the images taken today, please let us know where to email them:

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