Name: _____ **Today's Date:** _____
LAST FIRST M.

Mailing Address: _____ **Date of Birth:** _____
STREET APT.

_____ **Age:** _____
CITY ZIP

Phone: **(home)**_____ **(work)** _____ **Occupation:** _____

(cell)_____ **Email:** _____

Vision Insurance? ❑ No ❑ Other: _____

❑ Costco Employees & Family (Costco Vision I.D. #_____)

How did you first hear about our office? ❑ Website (www.eyecaresantarosa.com) ❑ Brochure / Flyer
❑ Google ❑ Yelp ❑ Costco Optical ❑ Other Optical ❑ Other: _____
❑ Friend / Family Member (name?: _____)

When was your last eye exam? _____

Do you wear contact lenses? ❑ **YES** ❑ **NO** (If NO, would you like to try contacts? ❑ Yes ❑ No)

Are you interested in laser surgery to lessen your need for glasses and contact lenses? ❑ **YES** ❑ **NO**

Do you have any allergies? ❑ **NO** ❑ **YES :** _____

Do you have any drug allergies? ❑ **NO** ❑ **YES :** _____ **Do you Smoke?** ❑ **NO** ❑ **YES**

Any reactions to anesthetics? ❑ **NO** ❑ **YES** **Pregnant/Nursing?** ❑ **NO** ❑ **YES**

List your medications: ❑ **None;** _____

Have any of the following eye conditions *EVER* affected You, a Family Member (sibling, parent, grandparent) or No one? (*Please give a response for each condition.*)

You	Fam	No		You	Fam	No	
❑	❑	❑	**Cataract**	❑	❑	❑	**Crossed Eyes / Lazy Eye**
❑	❑	❑	**Glaucoma**	❑		❑	**Eye Surgery**
❑	❑	❑	**Detached Retina**	❑		❑	**Eye Injury**
❑	❑	❑	**Diabetic Eye Problems**	❑		❑	**Eye Infection**
❑	❑	❑	**Macular Degeneration**	❑		❑	**Dry Eyes**

Other: _____

Are any of the following conditions *CURRENTLY* affecting You, *EVER* affected a Family Member, or No one?

You	Fam	No		You	No	
❑	❑	❑	**Diabetes**	❑	❑	**Headaches**
❑	❑	❑	**High Blood Pressure**	❑	❑	**Fever / Weight Loss**
❑	❑	❑	**Other Heart Disease**	❑	❑	**Asthma / Emphysema**
❑	❑	❑	**Stroke / Neurological Disease**	❑	❑	**Depression / Other Psychiatric**
❑	❑	❑	**Leukemia / Blood Disorders**	❑	❑	**HIV / AIDS**
❑	❑	❑	**Thyroid Condition**	❑	❑	**Skin / Ears / Nose / Throat Problems**
❑	❑	❑	**Arthritis**	❑	❑	**Stomach / Kidney / Urinary / Liver**

Other: _____

I understand and have answered the above questions to the best of my knowledge. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that services may or may not be covered or reimbursed by my vision &/or medical insurance, including not by Medicare/Medicaid/Medical. I have read and/or received a copy of our office **Privacy Policy** and have read and understand the **Importance of Pre-Exam Screening & Dilation, No Show Policy** and if want contact lenses, the **Contact Lens Informed Consent & Contact Lens Instructions**.

_____ _____ _____
Patient (or Guardian) Signature Print Name Date

_____ _____ ; _____ _____ _____ ; _____ _____ _____ ; _____ _____ _____ ; _____ _____
OD Init Date OD Init Date OD Init Date OD Init Date OD Init Date

Patient Name: _____ Date: _____

After reading the **Importance of Pre-Exam Screening & Dilation**, please mark your choices and initial in this box:

Patient read &/or told and understands importance of these services: Patient wants **Pre-Exam Screening**: ❑ **Yes** / ❑ **No** Patient wants **Dilation**: ❑ **Yes** / ❑ **No** Patient Init: _____ / OD:

COVID-19 Screening (to be answered on the day of visit):

❑ **Yes** / ❑ **No** In the past 48 hours have you had shortness of breath, difficulty breathing, or new loss of taste or smell? And/or, have you had at least two of these symptoms: fever; cough; chills with or without shaking; muscle pain; feeling achy or fatigued; unusual or new headache; sore throat; congestion; nausea or vomiting; diarrhea; tingling or numbness?

❑ **Yes** / ❑ **No** Within the past 10 days have you tested positive for COVID-19/coronavirus, &/or within the past 14 days have you had close contact with a person who tested positive or under quarantine for COVID-19/coronavirus?

❑ **Yes** / ❑ **No** Within the past 14 days have you, or anyone you live with, traveled such that you would need to self-quarantine as mandated by the state or local health agency?

❑ **Yes** / ❑ **No** I have a face covering or mask that covers from the bridge of my nose to the bottom of my chin, has no vents (can be closed with duct tape), and agree to wear it while inside the optometry office.

❑ **Yes** / ❑ **No** I agree to have my temperature taken, use hand sanitizer or wash hands as I enter the office, and agree to maintain 6 feet or more between myself and other patients.

Initial that you understand and agree to the following statements:

1. _____ I have answered the above health and safety questions and statements honestly and to the best of my knowledge.

2. _____ Even though Bradley I. Hall, O.D., Prof. Corp. and its doctors, assistants and other service providers are taking many precautions to limit any potential virus exposure, I understand that it is not possible to completely eliminate potential virus exposure in and around the office. I agree that I will not hold Bradley I. Hall, O.D., Prof. Corp. or any of its doctors, assistants and/or service providers responsible should I, or someone I come in contact with, become positively diagnosed with COVID-19 or the coronavirus that causes COVID-19. There are certain inherent risks associated with a visit to an eye exam office during a pandemic and I assume full responsibility for viral illness that may result, and further release and discharge Bradley I. Hall, O.D., Prof. Corp., its doctors, assistants and service providers for any COVID-19 related 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 accept the risk of exposure.

If you do not both pass this COVID-19 Screening and agree to all of the above statements, we will need to reschedule your exam appointment. If you do not pass the COVID-19 screening, you will need to immediately leave our office and the Costco warehouse and notify your primary doctor of not passing a COVID-19 screening. If you have any **emergency warning signs** for COVID-19 you should seek **medical attention immediately:** trouble breathing; persistent pain or pressure in the chest; new confusion or inability to stay awake; bluish lips or face; other severe symptoms.

Only the scheduled patient should enter our office. If necessary, one parent, guardian, care giver, translator or child may accompany the patient. This person will also need to pass these COVID-19 screening questions, agree to the above statements, use hand sanitizer, and allow us to measure their temperature.

_____ _____ _____

Patient (or Guardian) Signature Print Name Date