



Patient's Name: _____ Date of Birth: _____

Patient Status: (please circle) New or Established patient

Home Address: _____ City/State: _____ Zip Code: _____

Primary Phone Number: (please circle) Cell Home Work _____

Secondary Phone Number: (please circle) Cell Home Work _____

Email Address: _____ Gender: (please circle) Male or Female

Who referred you to us? _____

Do you have a history of the following eye conditions?

Personal History-Ocular

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Diabetes (Type I/II) |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Degeneration |
| <input type="checkbox"/> Glaucoma Suspect | <input type="checkbox"/> Retinal Hole |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Age-related Macular Degeneration | <input type="checkbox"/> Keratoconus |
| <input type="checkbox"/> Patching | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Inflammatory Disorder | <input type="checkbox"/> Dry Eye |
| <input type="checkbox"/> Strabismus | <input type="checkbox"/> Nystagmus |
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Other: _____ |

Eye Concerns

- | | |
|---|--|
| <input type="checkbox"/> Redness | <input type="checkbox"/> Eye Strain |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Severe Sensitivity to light |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Poor Night Vision |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Bothersome Night Glare |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Total Loss of Vision |
| <input type="checkbox"/> Headache | <input type="checkbox"/> None |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Other: _____ |

Contacts Lenses

Do you wear contact lenses? Yes No

If yes, what brand? _____



Financial and Office Policies

Thank you for entrusting Kat Eye Optical with your eye care needs. It is important to us that you have all the information that you need, including being aware of our office policies prior to your visit. Please review the following and sign below.

- We do not accept insurance of any kind. This enables us to keep our prices low and shop the free market for the best quality eyewear for our patients. We can help you file for reimbursement as an out-of-network transaction. For more details, please ask our staff.
- We do accept most Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA). We provide an itemized receipt at time of purchase and will keep the receipt on file. You may request a copy of the receipt at any time.
- Recalls and appointment confirmations will be done using the home, mobile, work number(s) and/or email address that you provide us.
- Missed appointments will incur a \$20.00 charge to your account, if the office is not notified 24 hours prior to the scheduled appointment time. Appointments are considered missed if patients have not arrived within 10 minutes of scheduled appointment time.
- For contact lens orders, payment is required in full.
- For custom eyewear orders, payment is required either in full or a 50% deposit before order is sent to the lab. If patient is placing a deposit, the balance must be paid in full prior to dispense.

I agree to the policies of Kat Eye Optical.

Patient Signature: _____.



Warranty and Return Policy

Kat Eye Optical specializes in custom eyewear and medical devices. While our outstanding service and attention to detail will minimize any issues that may arise, we will work with you to find an eyewear solution that fits your needs.

- Soft Contact Lenses: We will accept exchanges on unopened contact lenses, up to 30 days after purchase. Opened or used contact lenses cannot be returned/exchanged.
- Hard Contact Lenses: We accept exchanges on hard contacts lenses with an eye doctor's prescription change, up to 90 days after purchase. If the contact lens is damaged, please contact Kat Eye Optical and we will uphold the manufacturer's warranty. Warranty details are always available upon request.
- Eyewear: One remake is allowed per pair of glasses. The remake can occur for any reason, including but not limited to: restyle, prescription change, and non-adapt to multifocal lens, etc. If more than one remake is necessary, patient may be responsible for resulting lab costs.
 - Warranty: Defective frames are replaced with same or similar frame. All lenses come with a "One Time-One Year" Scratch Warranty. If abnormal damage occurs, repairs to eyewear purchased with Kat Eye Optical will be conducted at a reduced cost. If the frame, purchased from Kat Eye Optical, cannot be repaired, we will replace it at a reduced cost with same or similar frame.
- Professional fees are non-refundable.

I agree to the policies of Kat Eye Optical.

Patient Signature: _____.