Dr. Glenn Hiura, Optometrist
38433 20th Street East
Palmdale, CA 93550
661-947-2337; Fax: 661-947-4431

Welcome to our office!

Our office is located on the northwest corner of Palmdale Boulevard and 20th Street East across from the Carls Jr. restaurant on the same side of the Shell gas station and Gateway Center where the Vallarta grocery store is. We are located in the building that looks like a small house. There is a street level sign on 20th street East with Optometry, AV Sierra Dental, Atlas Health Clinic Chiropractor and a Dental Lab.

Before your exam takes place it is very important to gather some diagnostic information in order to perform your exam in the most efficient and effective manner.

Attached is a copy of the Diagnostic Information and Lifestyle Questionnaire and Notice of Privacy Practices. You will need to fill them out before you arrive for your exam. I have also included an explanation of our payment policies. If you have any questions please do not hesitate to call us at 661-947-2337.

Please bring all current glasses and sunglasses, as well as contact lenses, with you to your exam. Also bring your medical insurance information/card with you.

Thank you for making the appointment with us!

We look forward to meeting you!

Sincerely,

Glenn Hiura and Staff

DIAGNOSTIC INFORMATION QUESTIONNAIRE

□ Mr. □ Mrs. □ Ms. □ Dr. Sex: □ Male □ Female Today's Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (If minor) _____ Cell Phone: _____

Occupation: _____ Email: _____

Birth date: _____ Social Security #: _____ Date of last exam: _____

Were your pupils dilated: □ no □ yes Have you had a retinal exam? □ no □ yes

Medical Insurance Name: _____ ID #: _____

Who can we thank for referring you to our office? _____

How can we help you today?

Are you thinking of new glasses today? □ no □ yes
Are you thinking of new contact lenses today? □ no □ yes
Are you thinking of new sunglasses today? □ no □ yes

MEDICAL HISTORY

Do you have any allergies to medications ? □ no □ yes If yes, explain: _____

_____

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

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: *crossed eyes, lazy eye, dropping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:* _____

Are you pregnant and/or lactating? □ no □ yes

Do you wear glasses? □ no □ yes If yes, how old is your present pair of lenses: _____

Do you wear contact lenses? □ no □ yes If yes, how old is your present pair of lenses: _____

Type of contact lenses: □ Rigid Gas Permeable □ Soft □ Extended wear □ Other Are they comfortable? □ no □ yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	□	□	□	_____
Cataracts	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular degeneration	□	□	□	_____
Retinal detachment	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High blood pressure	□	□	□	_____
Kidney disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid disease	□	□	□	_____
Other _____	□	□	□	_____

Please turn this form over and complete side two.

SOCIAL HISTORY

(This information is kept strictly confidential. However, you may discuss this portion directly with the doctor.)

□ Yes, I would prefer to discuss my Social History information directly with the doctor. (Please check the box)

Do you drive? □ no □ yes If yes, do you have visual difficulty when driving? □ no □ yes If yes, please describe:

_____

Do you use tobacco products? □ no □ yes If yes, type/amount/how long? _____

Do you drink alcohol? □ no □ yes If yes, type/amount/how long? _____

Do you use recreational/illegal drugs? □ no □ yes If yes, type/amount/how long? _____

Have you ever been exposed to or infected with:

Gonorrhea	□ no □ yes
Hepatitis	□ no □ yes
HIV	□ no □ yes
Syphilis	□ no □ yes

REVIEW OF SYSTEMS – Do you have a problem with …

Eyes	**NO**	**YES**
Blindness	□	□
Loss of Vision	□	□
Distorted Vision/Halos	□	□
Blurred Vision	□	□
Double Vision	□	□
Cataracts	□	□
Crossed eyes	□	□
Flashes/Floaters in Vision	□	□
Dry eyes	□	□
Watery eyes	□	□
Red eyes	□	□
Mucous discharge	□	□
Burning or itching	□	□
Sandy or gritty feeling	□	□
Eye pain or soreness	□	□
Glare/Light sensitivity	□	□
Chronic eye infections	□	□
Tired eyes	□	□
Halos	□	□
Vision Therapy	□	□
Eye surgery	□	□
Eye injury	□	□
Retinal detachment	□	□
Glaucoma	□	□

Allergic/Immunologic	**NO**	**YES**
Hay fever	□	□
Medicine allergies	□	□
Constitutional symptoms		
Fever	□	□
Weight Loss	□	□
Cardiovascular		
Heart pain	□	□
High blood pressure	□	□
Vascular disease	□	□
Ears, Nose, Mouth, Throat		
Allergies/Hay Fever	□	□
Sinus problems	□	□
Chronic cough	□	□
Dry throat/mouth	□	□
Chronic ear infections	□	□
Endocrine		
Diabetes	□	□
Thyroid problems	□	□
Other glands	□	□
Gastrointestinal		
Diarrhea	□	□
Constipation	□	□
Ulcers	□	□
Genitourinary		
Genitals	□	□
Kidneys	□	□

Hematologic/Lymphatic	**NO**	**YES**
Anemia	□	□
Bleeding problems	□	□
Swelling	□	□
Integumentary		
Skin	□	□
Breast	□	□
Musculoskeletal		
Arthritis	□	□
Rheumatoid Arthritis	□	□
Muscle pain	□	□
Joint pain	□	□
Neurological		
Headaches	□	□
Migraines	□	□
Seizures	□	□
Psychiatric		
Nervous disorders	□	□
Depression	□	□
Compulsive behavior	□	□
Respiratory		
Asthma	□	□
Shortness of breath	□	□
Emphysema	□	□
Lung cancer	□	□

If you answered YES to any of the above or have a condition not listed, please explain and list medications.

_____

_____

_____

_____

_____

_____

_____ _____

Patient's Signature Date

Lifestyle Questionnaire

Patient Name: _____ Date of Visit: _____
Occupation: _____

Thank you for taking a few minutes to complete this questionnaire. It is designed to assist us in helping you select the perfect lenses, frames and/or contacts to suit your visual needs and lifestyle.

1. How many pairs of prescription glasses do you use and approximately how old are they? _____

2. Do you have sunglasses? ○ Yes ○ No Are they polarized? ○ Yes ○ No

3. Which of the following visual demands do you encounter on a regular basis? (Check all that apply)

○ Artificial lighting	○ Computer work	○ Potential eye hazards
○ Board work	○ Natural lighting	○ Reading
○ Close-up work	○ Paperwork	○ Other

3. Which of the following hobbies or activities do you participate in? (Check all that apply)

○ Auto repair	○ Fishing	○ Reading
○ Biking	○ Golf	○ Sewing/arts/crafts
○ Boating/water sports	○ Home repairs	○ Snow sports
○ Book keeping	○ Hunting/shooting	○ Spectator sports
○ Bowling	○ Jogging/running	○ Tennis
○ Competitive sports	○ Landscaping/gardening	○ Watching TV
○ Computer	○ Musical instrument	○ Welding
○ Drawing	○ Painting	○ Woodwork
○ Driving	○ Pilot	○ Horseback riding
○ Exercise	○ Racquetball	○ Other: _____

4. Do your eyes seem bothered by glare from any of the following situations:

○ Car headlights	○ Haze	○ Sunshine
○ Computer monitor	○ Night Driving	○ Traffic lights
○ Fluorescent lights	○ Reflections	○ Other:

5. If you currently wear glasses, do they ever fog up? ○ Yes ○ No Does this bother you? ○ Yes ○ No

6. If you wear contacts, do you have: (Check all that apply) ○ Current pair of prescription glasses
○ Sunglasses (purchased at a boutique, department / optical store) ○ Other:

7. Are you aware of the serious eye conditions that can develop from over exposure to UV rays? ○ Yes ○ No

8. What do you like about your current glasses or contacts (color, style, fit, etc.)?

_____

_____

9. What don't you like about your current glasses or contacts (weight, thickness, glare, etc.)?

_____

_____

HIPPA

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Dr. Glenn Hiura's office, we have always kept your health information secure and confidential. A law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service.

We may use your information to contact you. For example, we may need to send postcards to remind you of when your yearly exam is. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

If this practice is sold, your information will become the property of the new owner.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files or fax them.

You have the right to see and receive a copy of your health information with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement on your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in our file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

This notice goes into effect as of January 1, 2007.

ACKNOWLEDGMENT

I have read a copy of Dr. Glenn Hiura's Notice of Privacy Practices.

Signature: _____ Date: _____

Print name: _____

If signing for a minor please write the name of the Patient: _____

Dr. Glenn Hiura, Optometrist
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Financial Policy

Thank you for choosing Dr. Hiura. Our primary mission is to deliver the best and most comprehensive vision care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible, offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard, or Discover Card
- NO INTEREST[1] Payment Plans[2] from CareCredit
  - Allow you to pay over 6 months with NO INTEREST[1]
  - Convenient, low monthly payment plans[2] also available
  - No annual fees or pre-payment penalties

Please note:

All fees are due on the date of service

Dr. Hiura requires payment prior to sending frames to the lab.

Dr. Hiura charges $25 for returned checks.

When using old or previously used frames:
Please be informed that if you decide to use a previously used frame we and the labs we use will not be held responsible for damage on USED frames. They can break when new lenses are inserted.

Please NOTE: Insurance eligibility verification DOES NOT GUARANTEE COVERAGE once the claim is filed. If your Insurance denies the claim you are responsible for any services and materials given.

If you have any questions, please do not hesitate to ask. We are here to help you get the best vision care.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date.
Minimum monthly payment required
[2]Subject to credit approval.

Informed Consent for Contact Lens Wear For:_____

Dr. Glenn Hiura, Optometrist
38433 20th St East, Palmdale, CA 93550 (661) 947-2337

Benefits and Risks of Contact Lens Wear

Contact lens wear has many benefits versus eyeglasses including appearance, enhanced peripheral vision, and ease of wear during sports and in some cases better visual acuity. However, as with any other drug or device, contact lens wear is not without possible risks. Problems with contact lenses and care products could result in serious injury in the eye. The following are adverse affects (possible problems) that have been reported with the use of contact lenses: discomfort or feeling of something in the eye (a foreign body sensation); corneal abrasion (a scraped area); eye infection, including corneal ulcer (ulcerative keratitis); stinging, burning, itching (irritation); excessive watering of the eye (tearing); unusual eye secretions; redness of the eye; reduced sharpness of vision (poor visual acuities); blurred vision, rainbows or halos around objects; sensitivity to light (photophobia); dry eyes; corneal swelling; and lens wear becomes uncomfortable. Eye problems including corneal ulcers can develop rapidly and lead to permanent loss of vision, including blindness.

Daily wear lenses are not indicated for overnight wear and should not be worn while sleeping. Clinical studies have shown that the risk of serious adverse reactions are significantly increased when the lenses are worn overnight. The risk of ulcerative keratitis (corneal ulcer) has been shown to be greater among users of extended wear lenses than among users of daily wear lenses. The risk among extended wear users increases with the number of consecutive days that the lenses are worn between removals, beginning with the first overnight use. The risk can be reduced by carefully following directions for **What to Do If a Problem Occurs**, including cleaning or replacing of the lens case. Additionally, smoking increases the risk of ulcerative keratitis for contact lens users. If the patient experiences eye discomforts, excessive tearing, vision changes, redness of the eye or other problems with their eyes, they should immediately remove their lenses and promptly contact our office. It is recommended that contact lens wearers see their eye care practitioner twice a year or as directed. For routine contact lens check-ups, lenses should be worn at least four (4) hours.

What to Do If a Problem Occurs

If any of the above adverse affects (possible problems) or other abnormal symptoms occur: 1.) Immediately remove the lens(es) 2.) If the lens(es) are in any way damaged, do not put the lens(es) back on the eye. Return the lens(es) to the storage case and contact our office. 3.) If the lenses have dirt, an eyelash, or foreign body on them, or the problem stops and the lens(es) appear undamaged, thoroughly clean, rinse and disinfect/neutralize the lens(es); then reinsert them. 4.) If the above symptoms continue after removal or upon reinsertion of the lens(es) immediately and promptly contact our office. A serious condition such as infection, corneal ulcer, corneal visualization, or iritis may be present, and may progress rapidly. Less serious reactions such as abrasions, epithelial staining and bacterial conjunctivitis must be managed and treated properly to avoid complications.

Precautions

The following precautions must be taken to prevent damage to the eyes or to the contact lenses: 1.) Lens contamination may result in eye injury due to irritation or infection. To reduce the risk of contamination: always wash, rinse and dry hands before handling the lenses; do not use saliva, tap water, or anything other than sterile solutions recommend for use with the type of contact lenses (soft or rigid); when used, sterile non-preserved solutions must be discarded after the time specified in their label directions; do not get water in the eye while bathing, showering, or engaging in water activities 2.) Eye injury from irritation or infection and damage to lenses may result if cosmetics, lotions, soaps, creams, hair spray, deodorants, or aerosol products come in contact with the lenses. If sprays are used, keep eyes closed until the spray has settled. 3.) Environmental fumes, smoke, dust, vapors , and windy conditions must be avoided, in order to minimize the chance of lens contamination or physical trauma to the cornea. 4.) Always inform your employer that you wear contact lenses. Some jobs may require use of eye protective equipment or may require that you not wear contact lenses. 5.) Do not touch the lens with fingernails. 6.) Tweezers or other tools should not be used to remove a lens from the lens container. The lens should be poured into the hand. 7.) The lens must move freely on the eye for the continued health of the eye. If the lens sticks (stops moving on the eye) apply three drips of the recommended lubricating solution. Wait until the lens begins to move freely on the eye before removing it. If non-movement of the lens continues, immediately consult our office. 8.) Always consult our office before using any medicine in the eyes. 9.) Do not wear contact lenses while sleeping unless the eye care practitioner has prescribed an extended wear schedule. 10.) Before leaving our office, patients must be instructed on and demonstrate the ability to promptly remove the lenses or have someone else be able to remove lenses for them. 11.) If a soft contact lens is exposed to air while off the eye, it may become dry and brittle and need to be dehydrated. If the lens is adhering to a surface, apply sterile saline before handling it. To rehydrate the lens: handle the lens carefully; place the lens in its storage case and soak the lens in a recommended rinsing and storing solution for at least one hour until it returns to a soft state; clean and disinfect the rehydrated lens using a recommended lens care system; if after soaking, the lens does not become soft, the lens should not be used until examined by the eye care practitioner. 12) Contact lens prescriptions are valid for one (1) year. Contact lens prescriptions may be held from release if the patient is non-complaint with follow-up exams, wearing schedule or proper lens care. 13.) Since there are many variable to contact lens fitting, there is no guarantee that you will become a successful contact lens wearer. There is no way of foretelling how often or when your lenses will have to be refitted or replaced due to wear, improper handling, or changes in the refractive status of your eye. 14.) Do not change lens care solutions without consent of the Doctor.

Wearing Schedule

The wearing schedule should be determined by the eye care practitioner. Regular check-ups, as determined by the ye care practitioner, are extremely important. Daily Wear refers to wearing lenses less than 24 hours, while awake. Extended Wear refers to wearing lenses greater than 24 hours, including while asleep. Not every patient is able to wear contact lenses on an extended wear basis even if able to wear the same lenses for daily wear. Start daily wear before extended wear if so directed by the eye care schedule regardless of how comfortable the lenses feel. With extended wear, there may be increased risk of eye problems such as irritation, corneal thickening, and corneal ulcers. Therefore, periodic checkups are extremely important. The patient's wearing schedule is as follows:

Wearing Schedule:
__Daily Wear
__Extended Wear:
__1-2 nights *maximum* continuous wear
__Up to 6 nights *maximum* continuous wear
__Up to 30 nights *maximum* continuous wear

Lens Replacement Schedule:
__Conventional (yearly) replacement
__Planned: 1 2 3 month replacement
__Frequent: 1 2 week replacement
__Daily use disposables

Next Appointment(s):
__Dispensing lenses
__One week
__Every 6 months
X_Yearly Eye Exams
Opti-Free Lens Care System

I have read and understand the instructions on the care and use of my contact lenses. I understand the risks associated with contact lens wear and request to be fitted for contact lenses. I know that if I do not return to the Doctor as recommended, the Doctor, the Optician, and the contact lens manufacturer cannot be held responsible for any damage that may occur.

Patient's or Parent's/Guardian's signature:_____ Date:_____

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CONTACT LENSES AGREEMENT

__ 1. Review Solutions:
A. Rinsing Solution _____
B. Disinfection Solution_____
C. Lubricating Solution _____
D. Enzymatic Cleaner _____

__ 2. We recommend polarized or UV protected sunglasses because UV light can cause cataracts, macular degeneration and pingueculae.

__ 3. Having the correct Rx in a pair of back-up-glasses is important in case of infection and to help keep eyes healthy.

__ 4. When you are down to your last month's supply of contact lenses call us at 661-947-2337 to order more.

__ 5. Wearing schedule:
A. Daily Wear ____ hrs B. Extended Wear ____ hrs. C. Disposables, throw away every ____ days

__ 6. Contact lenses are medical devices which should be monitored by the doctor to determine that current prescription and health of the eyes to ensure successful contact lens wear.

__ 7. I understand that ***annual eye exams are necessary*** **and** sometimes even 6 months ***corneal evaluations are necessary*** to continue replacing contacts.

__ 8. I understand that there is an increased risk of infection or corneal ulcers that can lead to loss of vision, and even blindness, with contact lens wear. The risk increases if the contacts that are worn are extended wear. Complying with wearing times, care regimens and disposal schedules is highly recommended in order to minimize this risk.

__ 9. I understand that if sudden or prolonged red eyes, pain or irritation occurs, I should remove the lenses, discontinue contact lens use, and **call** this office **immediately**.

__ 10. DO NOT SLEEP WITH THE CONTACTS IN YOUR EYES!

Patient Signature: _____ Date:_____