

OPTOMETRY

Name: _____
Address: _____

Today's Date: ___/___/___
Home Phone: _____
Work Phone: _____

Gender: [] Male [] Female
Birth Date: ___/___/___ SS#: ___/___/___
Occupation: _____
Last Eye Exam: ___/___/___ Where: _____
Name of Medical Doctor: _____
Were you referred to our office? [] Yes [] No By whom? _____

Head of Household: _____
E-mail: _____
Employer: _____
Emergency Contact: _____ Phone: _____
Phone: _____ Last Medical Exam: ___/___/___

Insurance Information

Primary Insurance: _____
Group: _____
Medicare Part B #: _____
Secondary Insurance: _____

Policy Holder: _____ Policy/SS#: _____
Employer of Insured: _____
Medicaid #: _____
Policy Holder: _____ Policy/SS#: _____

Medical History

Do you have any seasonal or drug allergies? [] Yes [] No If yes, explain: _____
List any medications you take, including eye drops and over the counter medications: _____
List all major injuries, surgeries, and/or hospitalizations you have had, including any eye surgeries: _____

Note any of the following that you currently have or have had:

Table with 9 columns: Disease/Condition, Yes, No, Disease/Condition, Yes, No, Disease/Condition, Yes, No. Rows include High Blood Pressure, Diabetes, Thyroid Disorder, Heart Disease, Glaucoma, Crossed Eyes, Eye Infection, Floaters, Double vision, Cataracts, Iritis, Dry eyes, Eye injury, Droopy eyelid, Retinal Detachment, Macular Degeneration, Lazy Eye/Amblyopia, Flashes of light, Extreme nearsightedness, Blindness, Other.

Are you pregnant and/or nursing? [] Yes [] No If pregnant, how many weeks? _____
Do you wear glasses? [] Yes [] No If yes, when do you wear them? [] Full time [] Reading [] Computer [] Driving
Do you wear contact lenses? [] Yes [] No If yes, what type? [] Rigid/Hard [] Soft [] Bifocal [] Toric [] Extended wear
[] Disposable (brand _____ How often do you replace them? _____) Are your contacts comfortable? [] Yes [] No

Social History This information is kept strictly confidential.

Do you drive? [] Yes [] No Marital status: [] Married [] Single [] Divorced [] Widowed
Do you use tobacco products? [] Yes [] No If yes, type/ amount/ how long: _____
Do you drink alcohol? [] Yes [] No If yes, type/ amount/ how long: _____
Do you use illegal drugs? [] Yes [] No If yes, type/ amount/ how long: _____
Have you ever been exposed to or infected with: [] HIV [] Hepatitis [] Gonorrhea [] Syphilis [] None

Family History

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

Disease/Condition	Yes	No	Relationship	Disease/Condition	Yes	No	Relationship
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Crossed/ Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	Extreme nearsightedness	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems

Do you currently, or have you had any problems in the following areas:

System	Yes	No	System	Yes	No
Constitutional (fever, weight loss/gain)	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal (arthritis, muscles, bones)	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary (skin, breast)	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	Neurological (headaches, numbness)	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular/ Vascular (heart)	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (mental, depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory (lungs)	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (diabetes, thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal (stomach, intestines, liver)	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/ Hematologic (blood, lymph node)	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary (kidneys, urinary/reproductive tract)	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/ Immunologic (allergies, immune)	<input type="checkbox"/>	<input type="checkbox"/>

Mark any of the following that you would like more information on:

- Contact lenses
- Disposable Contacts
- Contacts for dry eyes
- Contact lenses for astigmatism
- Lenses for skiing, scuba diving, biking, hunting, or sports
- Colored contacts
- Bifocal Contacts
- No line bifocals
- Special lens designs for computer users
- Laser Vision Correction
- Vision and reading problems of children
- Lazy eye
- Light weight glasses and thinner lenses

Payment for all medical services is the responsibility of the patient and is expected at the time of service.

I agree to pay all attorney fees, court costs, filing fees, including charges or commissions up to 50% that may be assessed to me by any collection agency retained to pursue this matter. I further agree to pay interest at the rate of one and one half percent per month (18% per year). I understand there is a \$15.00 service charge for all returned checks.

I hereby authorize the release of medical information concerning my illness and treatment by this clinic to my insurance company, and the Health Care Financing Administrations or its agents. I also authorize release of my personal medical information to any doctor to whom I may be referred for a consultation. I authorize payment of medical benefits to provider or facility. I understand that any other information about me including prescriptions for glasses or contact lenses, will not be released to anyone else without my written consent.

I hereby authorize any procedures, including dilation of the eyes, as may be deemed necessary for my care. I also grant permission for treatment if this patient is a minor.

Signature of patient or legal guardian

Today's Date

Reviewed by Dr. _____

Dates: _____

Review by Patient _____

Initial and date (subsequent visits)