Robert L. Bass, O.D., F.A.A.O.
David R. Rose, O.D.

Welcome to Our Office

To ensure proper care, the doctors and your insurance company require a health and visual history from all patients as part of their eye examination. Thank you for your cooperation.

Patient History

Name: _____ Today's Date: _____

Date of Birth: ____/____/____ Age: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Home Phone: _____

Employer/Occupation: _____ Business Phone: _____

Spouse Name: _____ Cell Phone: _____

Prefered Method of Contact: ☐Home ☐Business ☐Cell ☐Email

Other Family Members Still Living at Home:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Date of your last exam: _____ Name of eye doctor: _____

Do you wear glasses? ☐ Yes ☐ No If yes, how old are your present glasses? _____

Do you wear contacts? ☐ Yes ☐ No If yes, age and type of contacts: _____

Do you have any complaints with your present glasses or contact lenses? _____

Whom may we thank for referring you to our office? Name:

Eye History

Do you or anyone in your in your immediate family have a history of the following?

	Family	*Self*	*No*	*Describe*
Blindness	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	_____
Crossed or Lazy Eye	☐	☐	☐	_____
Other	☐	☐	☐	_____

Visual Needs

☐ Computer ☐ Sports
☐ Reading ☐ Driving
☐ Boating ☐ Artwork
☐ Sewing ☐ Hunting
☐ Safety Eyewear
☐ Other _____

Have you ever had any eye injuries or surgery?

☐ Yes ☐ No If Yes, explain: _____

Health History

Do you or anyone in your in your immediate family have a history of the following?

	Family	*Self*	*No*	*Describe*
Neurologic (headaches, migraines, seizures, etc.)	☐	☐	☐	_____
Dermatological (skin)	☐	☐	☐	_____
Ear, nose, throat	☐	☐	☐	_____
Respiratory (breathing)	☐	☐	☐	_____
Vascular (blood pressure, heart)	☐	☐	☐	_____
Gastrointestinal	☐	☐	☐	_____
Genitourinary	☐	☐	☐	_____
Bones, joints, muscles	☐	☐	☐	_____
Blood, lymphatic (HIV, anemia~ hepatitis)	☐	☐	☐	_____
Endocrine (thyroid, diabetes)	☐	☐	☐	_____
Psychiatric, substance abuse (drug, alcohol, tobacco)	☐	☐	☐	_____

Are you allergic to any medications? ☐Yes ☐No If Yes, please explain _____

Please list all medications you are currently taking, including vitamins, birth control pills, over the counter drugs, etc.

_____

Height _____ **Weight** _____ **Blood Pressure** _____

Acknowledgement of Receipt of Privacy Policies

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

_____ _____

Signature Date

Insurance Authorization

I request that payment of authorized insurance benefits for any services provided to me, be made on my behalf to Optometric Associates, P.C. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. **I understand that I am responsible for charges not paid by my insurance plan within 90 days.**

_____ _____

Signature Date

Please check the method of payment for today's professional services:

☐ Cash ☐ Check ☐Mastercard ☐Visa ☐ Insurance preapproved by this office

Fees for professional services are due at the time services are rendered.
A deposit is required at the time materials are ordered