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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: _____
 Preferred 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?					Visual Needs	
	Family	Self	No	Describe		
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Computer	<input type="checkbox"/> Sports
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Reading	<input type="checkbox"/> Driving
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Boating	<input type="checkbox"/> Artwork
Crossed or Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Sewing	<input type="checkbox"/> Hunting
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Safety Eyewear	
					<input type="checkbox"/> 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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dermatological (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (breathing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular (blood pressure, heart)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bones, joints, muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood, lymphatic (HIV, anemia~ hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (thyroid, diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric, substance abuse (drug, alcohol, tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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.

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**