# WELCOME TO OUR PRACTICE

## PATIENT INFORMATION

Date_____

Mr. Mrs. Ms. Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: Male Female Birth Date _____ Age ____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? Yes No

Optometrist _____ Medical Doctor _____ Under their care at this time? _____

Driver's Lic. # _____ Emergency Contact _____ Referred By _____

## Who will be responsible for your account?

Self Spouse Father Mother Other _____

(If self, skip to next section)

Name _____ S.S# _____ Birth Date _____ Age ____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Business Tel. (_____) _____

## Spouse or other guarantor information (if different from above)

Name _____ Relation _____ S.S# _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Employer _____ Business Tel. (_____) _____

## Insurance Information

**Student:** Full-Time Part-Time Not School Name/Address _____

Married Divorced Legally Separated Widow Single _____

**Employed:** Full-Time Part-Time Retired Not

## Primary Insurance Company

**Insurance Type:** ☐ Vision ☐ Medical

Employer _____ Group # _____ Group Name _____

Business Address _____ Insured Party _____ Relation _____

Business Tel. (_____) _____ Plan _____ Sex: M F Birth Date _____

Ins. Co. Name _____ Street _____

Address _____ City,State,Zip _____

_____ Tel. (____) _____ Tel. (____) _____ S.S# _____

ID# _____

## Secondary Insurance Company

**Insurance Type:** ☐ Vision ☐ Medical

Employer _____ Group # _____ Group Name _____

Business Address _____ Insured Party _____ Relation _____

Business Tel. (_____) _____ Plan _____ Sex: M F Birth Date _____

Ins. Co. Name _____ Street _____

Address _____ City,State,Zip _____

_____ Tel. (____) _____ Tel. (____) _____ S.S# _____

ID# _____

## Eye Health History

Have you had any serious eye injuries, diseases, or surgeries: _____

Any family history of eye diseases: ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Other _____

**Please Check Any Which May Apply At This Time:**

- ☐ Blurred Distance Vision
- ☐ Blurred Reading Vision
- ☐ Sensitive to Sunlight
- ☐ Glare or Reflections
- ☐ Uncomfortable Glasses
- ☐ Uncomfortable Contacts
- ☐ Gritty/Scratchy Eyes
- ☐ Burning/Irritation
- ☐ Itching/Redness
- ☐ Tired Eyes
- ☐ Eye Pain
- ☐ Headaches
- ☐ Dry Eyes
- ☐ Watery Eyes
- ☐ Double Vision
- ☐ Sudden Losses of Visison
- ☐ Spots or Floaters in Vision
- ☐ Halos Around Lights

**Would you like to discuss any of the following options:**

- ☐ Contact Lenses
- ☐ Disposable Contacts
- ☐ Self-Darkening Lenses
- ☐ Special Minimum Thickness Lenses
- ☐ Light Weight Plastic Lenses
- ☐ Ultraviolet Protective Lenses
- ☐ Scratch Resistant Lenses
- ☐ Prescription Sunglasses
- ☐ Second Pair Discount - Eyeglasses
- ☐ Other Family Members in Need of Eyecare
- ☐ Safety Glasses or Sports Eyewear
- ☐ Cataract Surgery Options
- ☐ Refractive Surgery Options
- ☐ No-Line or Progressive Bifocals

## Medical History

Are you in good health? ○ Yes ○ No Height _____ Weight _____ Are you under the care of a physician? ○ Yes ○ No

Have you had any illness, operation, or been hospitalized in the past five years? ○ Yes ○ No

**Do yo have, or have you had, any of the following diseases, medical condicitons, or procedures?**

- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest Pain
- ☐ Heart attack(s)
- ☐ Irregular heart beat
- ☐ Cardiac pacemaker
- ☐ Heart surgery
- ☐ Bronchitis/ Chronic Cough
- ☐ Chronic Fatigue
- ☐ Mental health problems
- ☐ Asthma
- ☐ Hay fever/ Sinus problems
- ☐ Snoring/Sleep apnea
- ☐ Respiratory problems
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Check if you smoke
- ☐ Check if you use chewing tabacco
- ☐ Blood disorder
- ☐ Bruise Easily
- ☐ A history of drug abuse
- ☐ Abnormal bleeding
- ☐ Headaces
- ☐ Cholesterol
- ☐ Jaundice/Liver disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Fainting Spells
- ☐ Convulsions/Epilepsy
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Diabetes
- ☐ A history of alcohol abuse
- ☐ Sexually transmitted diseases
- ☐ Low blood sugar
- ☐ Check if you are on dialysis
- ☐ Arthritis/Joint disease
- ☐ Contagious diseases
- ☐ Delay in healing
- ☐ Anemia
- ☐ Tumor or growth
- ☐ Radition/Chemotherapy
- ☐ Contact lenses
- ☐ Immune system problems

## Medication and Allergies

**Are you now taking:**

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Nerver Pills | ○ | ○ | Pain Killers (including asprin) | ○ | ○ | Muscle Relaxers | ○ | ○ | Stimulants |
| ○ | ○ | Have you ever taken diet pills | ○ | ○ | Tranquilizers | ○ | ○ | Insulin | ○ | ○ | Antidepressants |
| ○ | ○ | Blood thinners (coumadin,Aspirin,Advil) | | | | | | | | | |

*Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):* _____

_____

_____

**Are you allergic to or had a reaction to:**

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ○ | ○ | Penicillin | ○ | ○ | Sulfa Drugs | ○ | ○ | Local anesthetic (numbing med) | ○ | ○ | Amoxicillin |
| ○ | ○ | Soy | ○ | ○ | Aspirin | ○ | ○ | Codeine or other narcotics | | | |
| ○ | ○ | Fish/Shellfish | ○ | ○ | Eggs/Yolk | ○ | ○ | Latex | | | |

***Please List any other medication or antibiotic you are allergic to:***

_____

_____

***Please list any allergies other than drug allergies:***

_____

_____

**1-4 below for women only:** (women note: antibiotics (such as penicilin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)

**1)** Is there a possibility of pregnancy? ○ Yes ○ No

**2)** Is there a possibility of pregnancy? _____

**3)** Are you nursing? ○ Yes ○ No

**4)** Are you taking birth control pills? ○ Yes ○ No

I certify that I have and and I understand the questions above. I acknowledge that my questions, if any, about the inquires set forth about have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

**Signature of patient:** *(Parent or Guardian if minor)* **X**_____ **X**_____ **Date: X**_____

# Fees and Payments

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depeding upon speical circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be reponsible for all collection costs, attorney fees, and court costs.

**Signature of patient:** *(Parent or Guardian if minor)* **X**_____ **Date: X**_____

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named the benefits otherwise payable to me.

**Signature of patient:** *(Parent or Guardian if minor)* **X**_____ **Date: X**_____

I hereby acknowledgee that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

**Signature of patient:** *(Parent or Guardian if minor)* **X**_____ **Date: X**_____