PATIENT INFORMATION

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. ☐ M ☐ F

_____ ____ _____ _____
First Name MI Last Name How would you like to be addressed?

_____ _____ _____ _____
Street Address City State Zip

☐ Caucasian ☐ African Amer. ☐ Asian ☐ Native Amer.
☐ Pacific Islander ☐ Hispanic ☐ Other ☐ Prefer not to say

_____ _____
Social Security Number Date of Birth

_____ _____ _____ ☐ OK to text
Home Phone Daytime Phone Cell Phone

Email Address_____ Occupation _____
(if we may contact you by email)

Who were you referred by? _____

INSURANCE INFORMATION

Do you have VISION insurance? ☐ Yes ☐ No ☐ Not sure Insurance Name: _____

Do you have MEDICAL insurance? ☐ Yes ☐ No ☐ Not sure Insurance Name: _____

Subscriber (Primary-Insured) Information

_____ ____ _____ _____
First Name MI Last Name Social Security Number

_____ **Patient's relationship to subscriber:**
Date of Birth ☐ Self ☐ Spouse ☐ Child ☐ Student ☐ Domestic Partner ☐ Other

Please Read:
When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.
You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations.
I acknowledge that I have received and/or read the *Notice of Privacy Practices* from Optometric Associates.

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

_____ _____
Patient/Guardian Signature **Date**

Do you wear glasses? Yes No **Do you wear Contacts**? Yes No

Reason for visit today: ☐ Routine Exam Other:_____

How long ago was your last exam? ☐ 1-2 Years ☐ 3-4 Years ☐ 5+ Years ☐10 Years ☐ Not sure ☐ Never

Are you interested in: ☐ New **Glasses** or sunglasses ☐ **Contact Lenses** ☐ Laser Vision Correction

Primary Care Physician_____

Medical Information

Tobacco usage (including e-cigarette or vaping): ☐ Never ☐ Former smoker ☐ Every day ☐ Occasional

Please list all current **Medications**, attach a list:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any **allergies to medications**:

_____

Are you currently pregnant/ nursing? Yes No

Eye History

☐ **Glaucoma** ☐ **Macular Degeneration** ☐ **Floaters** ☐ **Cataract Surgery**

☐ **Dry Eyes** ☐ **Lazy/crossed eye** ☐ **Eye Surgery**: _____

Medical History

☐ **Diabetes**: Type 1 or 2	☐ **Stroke/TIA**	☐ **Lymphoma**	☐ **HIV/AIDS**
☐ **High Blood Pressure**	☐ **Asthma**	☐ **Leukemia**	☐ **Allergic Disorder**
☐ **High Cholesterol**	☐ **Seizures**	☐ **Radiation/Chemo**	☐ **Hearing Loss**
☐ **Arthritis** ☐ Rheumatoid	☐ **Anxiety**	☐ **A-FIB**	☐ _____
☐ **Thyroid Condition**	☐ **Depression**	☐ **COPD**	☐ _____
Hypothyroidism/Hyperthyroidism	☐ **Hepatitis**	☐ **SLE** (Lupus)	☐ _____

☐ **Cancer:** Breast/Lung/Prostate/Colon/Other

Family History

Please check any family members who currently have or have had any of the following conditions:

Glaucoma	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather
Macular Degeneration	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather
High Blood Pressure	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather
Lazy/crossed eye	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandmother	☐ Grandfather