Mr.___ Mrs.___ Ms.___ Dr.___

Date ____/____/______

Last Name ________________________________ **First** ___________________________

Patient ☐ New / ☐ Previous

Address _______________________________________ **City**_______________________

Birth Date ____/____/______

State ______________ **Zip** ______________ **Email** _______________________________

Occupation__________________

Phone: **Home** _________________ **Work** _________________ **Cell** _________________

Last Eye Exam mo____/yr______

Vision Insurance _________________ ID# ________________ Medical Insurance ________________ ID# ________________

Primary Member's Name ___________________________ Primary's Last 4 SSN _______ Primary's Birth Date ____/____/____

Referred by: ☐ Family ☐ Friend ☐ Co-worker ☐ Insurance ☐ Drove by ☐ Internet Site ________________________

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: ____________________________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

____

____

IF YOU ARE A **PREVIOUS PATIENT** AND THERE ARE NO CHANGES IN YOUR OCULAR/MEDICAL OR FAMILY HISTORY YOU MAY CHECK THE APPROPRIATE BOX AND SKIP THAT SECTION. ☐ No change in Ocular Medical History ☐ No change in Family History

PATIENT'S OCULAR/ MEDICAL HISTORY

Last Medical Exam ____/____/______

Medical Dr's Name _____________________

List all major injuries, surgeries and/or hospitalizations you have had____

____

____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: ____

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of glasses? ______________

Do you wear contact lenses? ☐ no ☐ yes If yes, what is the brand and power? ______________________

Are they comfortable? ☐ no ☐ yes How often do you replace them? _________________________

Please check any conditions that you have or have had in the past:

☐ Loss of Vision	☐ Dryness	☐ Burning	☐ Chronic Infection of Eye/Lid
☐ Blurred Vision	☐ Mucous Discharge	☐ Foreign Body Sensation	☐ Styes or Chalazions
☐ Distorted Vision/Halos	☐ Redness	☐ Excess Tearing/Watering	☐ Flashes/Floaters in Vision
☐ Loss of Side Vision	☐ Sandy or Gritty Feeling	☐ Glare/Light Sensitivity	☐ Tired Eyes
☐ Double Vision	☐ Itching	☐ Eye Pain or Soreness	☐ Other__________________

FAMILY HISTORY

Please check any conditions that apply to your immediate family members:

☐ Blindness	☐ Macular Degeneration	☐ Cancer	☐ Kidney Disease
☐ Cataract	☐ Retinal Detachment	☐ Diabetes	☐ Lupus
☐ Crossed Eyes	☐ Retinal Disease	☐ Heart Disease	☐ Thyroid Disease
☐ Glaucoma	☐ Arthritis	☐ High Blood Pressure	☐ Other__________________

NOTICE OF PRIVACY

Acknowledgement of Receipt of Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal and our doctors and staff are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls. By signing below, I acknowledge that I have read/received the copy of the Notice of Privacy Practices for review.

Patient Signature ________________________________