Welcome to Optometric Associates, P.C. Thank you for choosing us for your eye care needs. Your overall health relates to your eye health so please do not skip any sections on these forms. If you have any questions please don't hesitate to ask.

__Mr. __Miss __Mrs. __Ms. __Male __Female

First Name MI Last Name Nickname

Street Address City State Zip Code

Social Security Number Date of Birth Home Phone Work Phone

Email Address Communication Preference Person Responsible for Account

Emergency Contact Phone Number Relationship to Patient

How were you referred to our office? (Please check one)

__Phone Book __School __Advertisement __Insurance Listing __Drive by Other_____

__Doctor Referral_____ __Patient Referral_____
Doctor's Name Patient's Name

PRIMARY Insurance Information:Patient's relationship to insured:(please check one) __Self __Spouse __Child __Other

Name/Address of Insurance Company Insurance Identification Number

Policy Holder's First Name MI Last Name Date of Birth __Male __Female

SECONDARY Insurance Info: Patient's relationship to insured:(please check one)__Self __Spouse__Child __Other

Name/Address of Insurance Company Insurance Identification Number

Policy Holder's First Name MI Last Name Date of Birth __Male __Female

PATIENT STATUS (check all that apply) __Single __Married __Other __Full Time Student __Part Time Student __Employed

Please Read:
In order to control the cost of billing, require that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.
I agree to allow my medical information to be shared to my insurance company for the sole purpose of billing and to any healthcare provider necessary for continuity of care.
I acknowledge that I am aware that Optometric Associates, P.C. has a Notice of Privacy Practices available to me at all times during normal business hours. I fully understand that I am protected under HIPAA and will be required to sign a release for any/all

Signature of Patient/Legal Guardian **Date**

RACE (please check all that apply) __Asian __White __Hispanic/Latino __Other

__Black/African American __Native Hawaiian/Other Pacific Islander __American Indian/Alaska Native

ETHNICITY __Hispanic or Latino __NOT Hispanic or Latino __Declined to Specify

Preferred Language: (please check all that apply) __English __Spanish __Chinese __French __German __Hindi

_____

Primary Care Physician/Clinic Name

_____

Address of Primary Care Physician City State Zip Code Phone Number w/Area Code

HEALTH HISTORY

What is the main reason for today's exam? _____ When was your last eye exam? _____

When was your last health exam? _____ Height: _____ Weight: _____

Past Illnesses or Injuries: _____ _____

Past Surgeries: _____ _____

Current Medications: _____ _____

_____ _____

_____ _____

Current Eye Drops: _____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	○ Yes	○ No	Dryness	○ Yes	○ No	Strabismus (Crossed Eyes)	○ Yes	○ No
Cataract	○ Yes	○ No	Excess Tearing/Watering	○ Yes	○ No	Blurred Vision Distance	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Eye Pain or Soreness	○ Yes	○ No	Blurred Vision Near	○ Yes	○ No
Retinal Detachment	○ Yes	○ No	Foreign Body Sensation	○ Yes	○ No	Distorted Vision (halos)	○ Yes	○ No
Color Blindness	○ Yes	○ No	Infection of Eye or Lid	○ Yes	○ No	Double Vision	○ Yes	○ No
Headaches	○ Yes	○ No	Itching	○ Yes	○ No	Floaters or Spots	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No	Mucous Discharge	○ Yes	○ No	Fluctuating Vision	○ Yes	○ No
Tired Eyes	○ Yes	○ No	Drooping Eyelid	○ Yes	○ No	Loss of Vision	○ Yes	○ No
Amblyopia (Lazy Eye)	○ Yes	○ No	Redness	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Burning	○ Yes	○ No	Sandy or Gritty Feeling	○ Yes	○ No			

GENERAL HEALTH CONDITION

List Medical Conditions: _____

_____

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Blindness	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Arthritis	○ Yes ○ No	Lupus	○ Yes ○ No
Color Blindness	○ Yes ○ No	Cancer	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No	Others	○ Yes ○ No

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? _____ Distance from Computer? _____

Do you drive? ○ Yes ○ No Mileage to work each way? _____

Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

SPECIAL EYEWEAR NEEDS

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Hobbies/ Interests : _____