

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

GENERAL HEALTH CONDITION

List Medical Conditions: _____

FAMILY HISTORY

Amblyopia (Lazy Eye)	<input type="radio"/> Yes	<input type="radio"/> No
Blindness	<input type="radio"/> Yes	<input type="radio"/> No
Cataract(s)	<input type="radio"/> Yes	<input type="radio"/> No
Color Blindness	<input type="radio"/> Yes	<input type="radio"/> No
Glaucoma	<input type="radio"/> Yes	<input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes	<input type="radio"/> No

Retinal Detachment	<input type="radio"/> Yes	<input type="radio"/> No
Strabismus (Eye Turn)	<input type="radio"/> Yes	<input type="radio"/> No
Arthritis	<input type="radio"/> Yes	<input type="radio"/> No
Cancer	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No
Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No

High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No
Kidney Disease	<input type="radio"/> Yes	<input type="radio"/> No
Lupus	<input type="radio"/> Yes	<input type="radio"/> No
Stroke	<input type="radio"/> Yes	<input type="radio"/> No
Thyroid Disease	<input type="radio"/> Yes	<input type="radio"/> No
Others	<input type="radio"/> Yes	<input type="radio"/> 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) Safety Glasses (gardening, woodworking, welding)

Occupational (mechanics, plumbers, pilots) 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 : _____