



Optometric Center, P.A.

Welcome to Our Office

Mr. Mrs.

Ms. Dr. _____ Social Security #: ____/____/____
First M.I. Last

Address: _____ Birthdate: ____/____/____ Male Female

City: _____ State: _____ Zip: _____ Date of Last Exam: ____/____/____ Eyes Dilated: Yes No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____ Occupation or Grade: _____ Employer: _____

Spouses or Parent's Name: _____ Spouse or Parent's Work Number: _____
CIRCLE ONE CIRCLE ONE

In Case of Emergency Notify: _____ Phone Number: _____

Whom may we thank for referring you to our office: _____

Or were you introduced by: Phone Book Insurance Company Location Other _____

<p>What is the major purpose of your visit? <input type="checkbox"/> Annual Check-up <input type="checkbox"/> New Glasses <input type="checkbox"/> New Contacts <input type="checkbox"/> Lasik</p> <p><input type="checkbox"/> Eye Health Evaluation <input type="checkbox"/> Other _____</p>
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Do you currently wear glasses? Yes No Do you currently wear contact lenses? Yes No

Have you ever worn contact lenses? Yes No

Any problems with your present contact lenses or glasses? Yes No If yes, please explain: _____

Are you interested in any of the following? Contact Lenses Sunglasses Refractive Surgery Corneal Refractive Therapy

Special Interests: Hobbies, sports, occupational needs _____

Insurance Information - please present card at time of service			
_____	_____	_____	_____
Medical Insurance	Vision Insurance	Insured's Name	D.O.B.
_____	_____	_____	_____
Insured's Identification	Employer	Relationship to Patient	

PAYMENT IS DUE AT TIME OF SERVICE

METHOD OF PAYMENT: CASH CHECK CREDIT CARD

ON PURCHASE OF MATERIALS, WE REQUIRE 1/2 DOWN AT TIME OF ORDERING AND THE OTHER 1/2 IS DUE AT TIME OF DISPENSING.

I request that payment of insurance benefits be made on my behalf to **Optometric Center** for any services furnished my by **Optometric Center**. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits payable for related services.

I authorize and agree to pay for all services rendered to me not covered by Medicare or other insurance.

SIGNATURE X _____ **DATE** _____

(PLEASE COMPLETE BACK SIDE OF FORM)

FOR OFFICE USE ONLY

SYMPTOMS: Are you currently experiencing any of the following:

- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Far Vision | | Tearing | | Floaters | | Head Trauma | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Near Vision | | Burning | | Headaches | | Computer Eye Strain | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Redness | | Pain In/Around Eye | | Double Vision | | Other _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Itching | | Flashes of Light | | Sensitivity to Light | | | |

EYE DISEASES: Do you have any of the following eye diseases?

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataract | | Diabetic Retinopathy | | Lazy Eye | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | | Macular Degeneration | | Injury | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Detached Retina | | Crossed Eyes | | Other _____ | |

FAMILY HISTORY: Have your parents, grandparents or siblings had any of the following?

- | | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Yes | No | Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blindness | | Macular Degeneration | | Heart Disease | | Diabetes | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataract | | Retinal Detachment | | Stroke | | Cancer | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | | High Blood Pressure | | Thyroid | | Other _____ | |

CURRENT CONDITIONS: Do you currently have any of the following conditions?

- | | | | | | |
|--------------------------------|--------------------------|------------------------------------|--------------------------|--------------------------------|--------------------------|
| Yes | No | Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | | Ears/Mouth/Throat Problems | | Asthma | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | | Blood Disorders/Prolonged Bleeding | | Emphysema (other lung disease) | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular Heartbeat | | HIV/AIDS | | _____ | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ | |
| High Cholesterol | | Skin/Acne/Rosacea | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Diabetes or Thyroid Disorder | | Joint/Muscle Pain | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Stomach/Intestinal Problem | | Stroke/MS/Neurologic Disorder | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Kidney/Urinary/Genital Disease | | Psychiatric Problems | | | |

Do you have any drug sensitivities / allergies? Yes No If yes, please list: _____

Are you currently under a physician's care? Yes No Family Physician: _____

CURRENT MEDICATIONS: Are you currently taking any prescription or over the counter medications?

No Yes

If yes, please list:

Medication: _____ For: _____ Medication: _____ For: _____

Medication: _____ For: _____ Medication: _____ For: _____

Others: _____