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 _____

What is the major purpose of your visit? ❑ Annual Check-up ❑ New Glasses ❑ New Contacts ❑ Lasik
❑ Eye Health Evaluation ❑ Other _____

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	
❑	❑	Blurred Far Vision	❑	❑	Tearing	❑	❑	Floaters	❑	❑	Head Trauma
❑	❑	Blurred Near Vision	❑	❑	Burning	❑	❑	Headaches	❑	❑	Computer Eye Strain
❑	❑	Redness	❑	❑	Pain In/Around Eye	❑	❑	Double Vision	❑	❑	Other _____
❑	❑	Itching	❑	❑	Flashes of Light	❑	❑	Sensitivity to Light			

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

Yes	No		Yes	No		Yes	No	
❑	❑	Cataract	❑	❑	Diabetic Retinopathy	❑	❑	Lazy Eye
❑	❑	Glaucoma	❑	❑	Macular Degeneration	❑	❑	Injury
❑	❑	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	
❑	❑	Blindness	❑	❑	Macular Degeneration	❑	❑	Heart Disease	❑	❑	Diabetes
❑	❑	Cataract	❑	❑	Retinal Detachment	❑	❑	Stroke	❑	❑	Cancer
❑	❑	Glaucoma	❑	❑	High Blood Pressure	❑	❑	Thyroid	❑	❑	Other _____

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

Yes	No		Yes	No		Yes	No	
❑	❑	Allergies	❑	❑	Ears/Mouth/Throat Problems	❑	❑	Asthma
❑	❑	High Blood Pressure	❑	❑	Blood Disorders/Prolonged Bleeding	❑	❑	Emphysema (other lung disease)
❑	❑	Irregular Heartbeat	❑	❑	HIV/AIDS	❑		_____
❑	❑	High Cholesterol	❑	❑	Skin/Acne/Rosacea			_____
❑	❑	Diabetes or Thyroid Disorder	❑	❑	Joint/Muscle Pain			
❑	❑	Stomach/Intestinal Problem	❑	❑	Stroke/MS/Neurologic Disorder			
❑	❑	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: _____