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: _____ Employer: _____

Spouse's or Parent's Name: _____ Spouse's or Parent's Number: _____

❑ Telephone

Preferred Language: _____ Race: _____ Ethnicity: _____ Communication Preference: ❑ Mail

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

Primary Insured Name: _____ D.O.B: ___/___/___ Relationship: ❑ Self ❑ Other: _____
❑ Spouse

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: _____

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 to me by **Optometric Center.** I authorize any holder of medical information about me to release in 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 needed to me not covered by Medicare or other insurance.

SIGNATURE X _____ **DATE** _____

(PLEASE COMPLETE BACK SIDE OF FORM)

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 Retinopothy	❑	❑	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	❑	❑	Smoker
❑	❑	High Cholesterol	❑	❑	Skin/Acne/Rosacea	❑	❑	_____
❑	❑	Diabetes I / II	❑	❑	Joint/ Muscle Pain	❑	❑	_____
❑	❑	Thyroid Disorder	❑	❑	Stroke/MS/Neurologic Disorder			
❑	❑	Stomach/Intestinal Problem	❑	❑	Psychiatric Problems			
❑	❑	Kidney/Urinary/Genital Disease						

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?

Yes No

❑ ❑ If yes, please list:

Medication: _____ **For:** _____ **Dosage:** _____

Medication: _____ **For:** _____ **Dosage:** _____

Medication: _____ **For:** _____ **Dosage:** _____

Medication: _____ **For:** _____ **Dosage:** _____

Medication: _____ **For:** _____ **Dosage:** _____

Others: _____

Doctor

Signature: _____ Date: _____