PATIENT INFORMATION

PATIENT NAME:_____**DATE:**_____

NICKNAME: _____ **SEX: Male __ Female __** **MARRIED: __ Single __**

ADDRESS:_____**CITY:**_____**STATE:**_____**ZIP:**_____

HOME PHONE:_____**CELL PHONE:**_____**WORK PHONE:**_____

EMAIL:_____ **DOB:**_____**SSN:**_____

EMPLOYER (OR SCHOOL):_____

OCCUPATION (OR GRADE):_____

ARE YOU REQUIRED TO WEAR SAFETY GLASSES AT WORK? YES:_____ **NO:**_____

PRIMARY CARE PHYSICIAN:_____**Phone:**_____**Fax:**_____

OTHER PHYSICIANS: _____**Phone:**_____**Fax:**_____

WHO MAY WE THANK FOR YOUR REFERRAL? _____

PLEASE READ AND SIGN:
I authorize release of any information necessary to process any claims for services received in this office. I further authorize payment for any claims to be made to this office. By signing below you agree that you are financially responsible for co-pays, deductibles and fees not paid for by insurance.

OFFICE PAYMENT POLICY:
1. Payment on deductibles, co-payments, and non-covered charges are due at the time of service.
2. We accept cash, checks, debit cards, American Express, Discover, MasterCard,Visa, Flex Spending and HSA.
3. All balances are subject to 1.5% charge or $3.00/month, whichever is greater.
4. Payment plans are NOT accepted.

RESPONSIBLE PARTY SIGNATURE:_____DATE:_____

CIRCLE ONE: PATIENT PARENT GUARDIAN

Thank you for choosing our office!

PATIENT MEDICAL HISTORY

PATIENT NAME:_____ **DATE:**_____

REASON FOR VISIT: Blurry Vision __ Headaches __ Eye Health __ Other _____

REVIEW OF SYSTEMS FOR PATIENT: *Please circle any conditions below that apply*

CONSTITUTION: Cancer, Disability, Fatigue, Weight gain/loss, Other_____ ❑ **None**

ENT: Dry mouth, Hearing Loss, Laryngitis, Sinusitis,Other_____ ❑ **None**

NEURO: Autism, Cerebral Palsy, Epilepsy, Migraine, MS, Stroke, Tumor, Other_____❑ **None**

PSYCHIATRIC: Anxiety, Attention deficit, Bipolar, Depression, Other_____ ❑ **None**

CARDIOVASCULAR: Heart Disease,Hypertension, Stroke,Vascular Disease,Other_____❑ **None**

RESPIRATORY: Asthma,Bronchitis,COPD,Emphysema,Sleep apnea,Smoker,Other_____❑ **None**

GI: Acid reflux, Colitis, Crohn's, Celiac, Ulcer, Other_____ ❑ **None**

GU: Herpes,Kidney Disease,Pregnant,Prostate Disease,Nursing,STD, Other_____❑ **None**

MUSC/SKEL: Arthritis, Fibromyalgia, Gout, MS,Osteoporosis,Other_____❑ **None**

INTEGUMENTARY: Cold Sores,Eczema,Psoriasis,Rosacea, Shingles, Other_____❑**None**

ENDOCRINE: Diabetes (Type 1/Type 2),Hormonal Dysfunction,Thyroid,Other_____❑ **None**

HEMATOLOGICAL/LYMPHATIC: Anemia, Hypercholesteremia, Ulcer,Other_____ ❑ **None**

ALLERGY/IMMUNE: Lupus,Rheumatoid Arthritis, Sjogren's Syndrome _____❑ **None**

Drug allergies: Penicillin,Sulfa,Other_____ ❑ **None**

Environmental allergies: Dust, Foods(specify), Latex, Mold, Seasonal, other _____❑ **None**

EYE HISTORY: Amblyopia, Cataract, Dry eyes,Glaucoma, Injury, Macular Degeneration, Ocular Surgery,Strabismus, Other_____❑ **None**

EYE HISTORY FOR 1-Father, 2-Mother, 3-Brother, 4-Sister, 5-Son, 6-Daughter:
Circle problem, then Indicate who has what problem by placing the number associated with that person next to the circled item: Amblyopia, Cataract,Glaucoma, Macular degeneration, Other_____ ❑ **None**

MEDICAL HISTORY FOR 1-Father, 2-Mother, 3-Brother, 4-Sister, 5-Son, 6-Daughter:
Circle problem, then Indicate who has what problem by placing the number associated with that person next to the circled item: Arthritis, Cancer, Diabetes, Heart Disease, Thyroid, Hypertension, Other _____ ❑ **None**

SOCIAL HISTORY: Alcohol use: ❑ Yes _____/week ❑ No

Tobacco use: ❑ Yes _____/day ❑ No (❑ Never smoked ❑ Former smoker)

SUNGLASSES: What are presently using for sun protection? Prescription Sunglasses Sun-Clips Fit-Over Sunglasses Off-Shelf Sunglasses No Sun Protection

CURRENT MEDICATIONS

PATIENT NAME:_____**DATE:**_____

CHECK CATEGORY, CIRCLE LISTED DRUG OR LIST ADDITIONAL MEDICATIONS.
***If known, include dosage & frequency taken. If available, provide medication list**

❑**Allergy/Cold:** Allegra, Benadryl, Claritin, Dimetane, zyrtec, Other _____**mg**
❑ **Antacid:** Aciphex, Nexium, Prilosec, Zantac, Other _____**mg**
❑**Anti-anxiety/Antidepressant:** Paxil, Prozac, Wellbutrin, Zoloft, Other _____**mg**
❑ **Antibiotic:** Amoxicillin, Azithromycin, Cephalexin, Doxycycline, Other_____**mg**
❑ **Anti-cholesterol:** Lipitor, Lovastatin, Pravachol, Zocor, Other _____**mg**
❑ **Anticoagulant:** Aspirin, Coumadin (Warfarin), Heparin, Other _____**mg**
❑ **Anti-Inflammatory/Immunosuppressant:** Prednisone/ Prednisolone, Other _____**mg**
❑ **Diabetes: G**lipizide (Glucotrol), Glyburide, Insulin, Metformin, Other_____**mg**
❑ **Heart/Hypertension:** Amlodipine, **L**asix, Lisinopril, Lopressor, Plavix, Other_____**mg**
❑ **Hormone replacement:** Estrogen, Levothyroxin, Synthroid, Testosterone, Other_____**mg**
❑**NSAID:** Advil, Motrin(Ibuprofen), Aleve, Voltaren, Other_____**mg**
❑ **Respiratory:** Advair, Albuterol, Flovent, Proventil, Singulair, Ventolin, Other _____**mg**

❑ **Drugs not listed in any of the above categories or if more space is needed:**

_____
_____
_____
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_____
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_____
_____
_____

*****Note:** If you are able to provide a current medication list, you do not need to fill out any of the above.