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Board-Certified Optometric Physicians

Diagnosis and Treatment of Eye Diseases *Contact Lenses*
Adult and Pediatric Eyecare *Fashion Eyewear*

WELCOME TO OUR OFFICE

In order to properly serve you, please complete both sides of the following questionnaire. This will become part of your office record and will be held in strict confidence. **Please Print.**

Today's Date_____/_____/_____

Last Name_____, First Name_____ MI_____ Sex M F

Marital Status: S M D W Age_____ Date of Birth_____/_____/_____ SS#_____

If Minor, Parent/Guardian's Name_____ Guardian's SS#_____

Street Address_____

City_____ State_____ Zip Code_____

Phone (H)_____-_____-_____ (W)_____-_____-_____ (Cell) _____-_____-_____

Employer_____ Occupation_____

If student, school attended_____ Primary Language Spoken_____

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

INSURANCE INFORMATION (Please provide your card so that we may make a photocopy)

Medical Insurance_____ID#_____

Name of Insured_____ Insured's SS # _____

Insured's Relationship to Patient_____ Employer of Insured_____

Supplemental or Additional Insurance_____ ID#_____

Medical Doctor_____ Phone_____-_____-_____

AUTHORIZATION OF RESPONSIBLE PARTY: Please Read Carefully

I authorize the release of any information concerning my (or my dependent's) health history, including any diagnoses, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits where applicable. I also hereby authorize payment of insurance benefits otherwise payable directly to me to the doctor who accepts assignment. I understand that any copayments are due on the date of service. I agree to accept responsibility for any non-covered goods or services rendered to myself or to my dependents. I attest that the insurance information I am providing is true and accurate and that in the event that my insurance information should change, I am responsible for notifying this office of the change. In the event that the insurance information I provide is inaccurate, I understand that I will be responsible for any and all charges incurred as a result of claim denial. I understand that I may be charged a collection fee of 15% or the maximum allowed by law, on any unpaid balance, as well as any applicable collection fees. In the event of a returned check, I understand that I may be charged a returned check fee of $25 or the maximum allowed by law.

X_____
Signature of Patient or Responsible Party Date

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If "YES", please give an explanation. If no, please circle **N**.

Constitutional
Fever Y N _____
Weight loss Y N _____
Malaise Y N _____
Fatigue Y N _____

Ears, Nose, Mouth, Throat
Sinus congestion Y N _____
Chronic cough Y N _____
Dry mouth/throat Y N _____
Decreased hearing Y N _____
Difficulty swallowing Y N _____

Cardiovascular
High blood pressure Y N _____
Heart attack/angina Y N _____
Arrhythmia Y N _____
Heart failure/block Y N _____
High cholesterol Y N _____

Respiratory
Shortness of breath Y N _____
Wheezing Y N _____

Musculoskeletal
Muscle pain/weakness Y N _____
Joint pain Y N _____

Integument
Chronic rash Y N _____
Changing growth Y N _____
Skin cancer Y N _____
Breast cancer Y N _____

Gastrointestinal
Ulcers Y N _____
Gastritis Y N _____

Genitourinary
Kidney stones Y N _____
Prostate enlargement Y N _____

Neurological
Stroke Y N _____
TIA Y N _____
Headaches Y N _____
Psychiatric (depression) Y N _____

Endocrine
Thyroid disease Y N _____
Pituitary Y N _____
Diabetes Y N _____
Menstrual abnormalities Y N _____

Hematologic/Lymphatic
Bleeding disorder Y N _____
Lymphoma/leukemia Y N _____

Allergic/Immunologic
Asthma Y N _____
Seasonal allergies Y N _____

Other symptoms not noted above Y N
_____
_____

FAMILY HISTORY

Did/does someone in your family have:

Glaucoma Y N _____
Diabetes Y N _____
Cancer Y N _____
Heart attack Y N _____
Stroke Y N _____
Other Y N _____

SOCIAL HISTORY

Do you drink alcohol? Y N
If yes, how many glasses a day _____

Do you smoke? Y N Quit

If yes, how many packs a day and for how long
_____

PAST HISTORY (complete each line)

List all medications (including OTC medications and vitamins) you take:
None_____
List all eye medications you take None_____
List all medical illnesses and injuries None/ SEE ABOVE_____
List any surgeries you have had None_____
Do you have any allergies to prescription or OTC medications Y /N List _____

_____ ____/____/_____
PHYSICIAN SIGNATURE **DATE**

Please make sure both sides are COMPLETED IN FULL 3/15/2010