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Board-Certified Optometric Physicians

Diagnosis and Treatment of Eye Diseases
Adult and Pediatric Eyecare

Contact Lenses
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 work? (list job) Y N ______

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 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