Welcome To Our Office – Optometric Associates, LLC

PATIENT INFORMATION

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. ☐ M ☐ F

_____ ____ _____ _____

First Name MI Last Name How would you like to be addressed?

_____ _____ _____ _____

Street Address City State Zip

☐ Caucasian ☐ African Amer. ☐ Asian ☐ Native Amer.
☐ Pacific Islander ☐ Hispanic ☐ Other ☐ Prefer not to say

_____ _____

Social Security Number Date of Birth

_____ _____ _____ ☐ OK to text

Home Phone Daytime Phone Cell Phone

Email Address_____ Occupation _____
(if we may contact you by email)

Primary Care Physician _____ Who were you referred by _____

Do you have VISION insurance? ☐ Yes ☐ No ☐ Not sure Insurance Name: _____

Do you have MEDICAL insurance? ☐ Yes ☐ No ☐ Not sure Insurance Name: _____

Primary Insurance Holder Information

_____ ____ _____ _____

First Name MI Last Name Social Security Number

_____ **Patient's relationship to Insured:**

Date of Birth ☐ Self ☐ Spouse ☐ Child ☐ Student ☐ Domestic Partner ☐ Other

Person responsible for bill: (If different than Insured) Is this person a patient here? **Y N**

_____ ____ _____ _____

First Name MI Last Name Primary Phone

_____ _____ _____ _____

Street Address (if different from patient**)** City State Zip

Please Read:

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and health care operations.

I acknowledge that I have received and/or read the *Notice of Privacy Practices* from Optometric Associates, LLC.

_____ _____

Patient/Guardian Signature **Date**

Welcome To Our Office – Optometric Associates, LLC

Patient Name:_____ **Date**:_____

Do you wear glasses? Yes No **Do you wear Contacts**? Yes No

How long ago was your last exam? ☐ 1-2 Years ☐ 3-4 Years ☐ 5+ Years ☐10 Years ☐ Not sure ☐ Never

Are you interested in: ☐ New **Glasses** or sunglasses ☐ **Contact Lenses** ☐ Laser Vision Correction

Medical Information

Tobacco usage: ☐ Never ☐ Former smoker ☐ Every day ☐ Occasional

Please list all current **Medications**, or attach a list of medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any **allergies to medications**:

_____

Eye History

☐ **Glaucoma** ☐ **Macular Degeneration** ☐ **Cataract** ☐ **Floaters**

☐ **Dry Eyes** ☐ **Lazy/crossed eye** ☐ **Eye Surgery**: _____

Medical History

☐ **Diabetes**: Type 1 or 2	☐ **Stroke/TIA**	☐ **Lymphoma**	☐ **HIV/AIDS**
☐ **High Blood Pressure**	☐ **Asthma**	☐ **Leukemia**	☐ **Allergic Disorder**
☐ **High Cholesterol**	☐ **Seizures**	☐ **Radiation/Chemo**	☐ **Hearing Loss**
☐ **Arthritis** ☐ Rheumatoid	☐ **Anxiety**	☐ **A-FIB**	☐ _____
☐ **Thyroid Condition**	☐ **Depression**	☐ **COPD**	☐ _____
☐ **Cancer:**	☐ **Hepatitis**	☐ **SLE** (Lupus)	☐ _____

- Breast/Lung/Prostate/Colon/Other

Family History

Please check any family members who currently have or have had any of the following conditions:

Glaucoma	☐ Mother	☐ Father	☐ Sister	☐ Brother
Macular Degeneration	☐ Mother	☐ Father	☐ Sister	☐ Brother
Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother
High Blood Pressure	☐ Mother	☐ Father	☐ Sister	☐ Brother
Lazy/crossed eye	☐ Mother	☐ Father	☐ Sister	☐ Brother