

Welcome To Our Office – Drs. Glosik, Glosik & Andler

PATIENT INFORMATION

Mr. Miss Mrs. Ms. Dr. Sr. Fr. _____

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

Home Phone Daytime Phone Cell Phone OK to text

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

Primary Care Physician Who were you referred by? _____

Information of person responsible for bill: Is this person a patient here? **Y N**

First Name MI Last Name Primary Phone (include area code)

Street Address (if different from patient) City State Zip

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

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

Subscriber (Primary-Insured) Information

First Name MI Last Name Social Security Number

Patient's relationship to subscriber:

Date of Birth Self Spouse Child Student Domestic Partner Other

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

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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 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

Eye History

- [] Glaucoma [] Macular Degeneration [] Cataract [] Floaters
[] Dry Eyes [] Lazy/crossed eye [] Eye Surgery: _____

Medical Information

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

Please list any medication allergies:

Tobacco usage (including e-cigarette): [] Never [] Former smoker [] Every day [] Occasional
Are your currently pregnant or nursing? [] Yes [] No [] NA

Family History

Please circle 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