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 ______

Social Security Number ______ Date of Birth ______

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

Home Phone ______ Daytime Phone ______ Cell Phone ______ ☐ OK to text

Email Address______________________________ Occupation ______________________
(if we may contact you by email)

Who were you referred by? ______________________

INSURANCE INFORMATION

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 ______

Date of Birth ______

Patient's relationship to subscriber:
☐ 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.

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay.

______________________________ ______________
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

Primary Care Physician___________________________

Medical Information

Tobacco usage (including e-cigarette or vaping): ☐ Never ☐ Former smoker ☐ Every day ☐ Occasional

Please list all current **Medications**, attach a list of medications, or authorize us to upload list into your health record:
☐ I consent to allowing Optometric Associates to upload my medication list via Surescripts. (Initial _______)

_____________________________ _____________________________ _____________________________
_____________________________ _____________________________ _____________________________
_____________________________ _____________________________ _____________________________

Please list any **allergies to medications**:
____

Are you currently pregnant/ nursing? Yes No

Eye History

☐ **Glaucoma** ☐ **Macular Degeneration** ☐ **Floaters** ☐ **Cataract Surgery**
☐ **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:** Breast/Lung/Prostate/Colon/Other	☐ **Hepatitis**	☐ **SLE** (Lupus)	☐ _________________

Family History

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

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