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

PATIENT INFORMATION

☐ M ☐ F

_____ ____ _____ _____
First Name MI Last Name Preferred Name

_____ _____ _____ _____
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

Phone_____ ☐ OK to text Email address_____
(if we may contact you by email)

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**:_____

Developmental and Health History ***(complete if patient under age 5)***

Length of pregnancy in weeks _____ Birth Weight _____ Was oxygen used at birth Yes/ No

Parents age at time of birth Mom_____ Dad_____

Complications/issues during pregnancy or delivery _____

Medical

Pediatrician _____ Last Exam Date _____

Are immunizations up to date? Yes / No

Major illnesses and/or head/eye injuries _____

Diagnosed or suspected developmental delays _____

Does child have any known food or drug allergies _____

Medications taken regularly _____

Family members who have an eye condition (lazy eye, eye turn, etc.) _____

Vision

Last Eye Exam _____ □ Not sure □ Never

Current Vision Correction: □ Glasses □ Contact Lenses □ Both □ None

Visual Symptoms Checklist ***(for school-aged children)***

Grade _____ School _____

- □ Frequently skips or repeats lines when reading
- □ Poor reading comprehension
- □ Tilts head or closes one eye when reading
- □ Has difficulty copying from the chalkboard
- □ Avoids reading and near work
- □ Has a short attention span with reading and schoolwork
- □ Has difficulty completing assignments in time allotted