Welcome to Our Office

PATIENT INFORMATION

Patient Full Name:• Dr. • Mr. • Mrs. • Ms._____ Date: ____/____/___

Address: (*Street & Mailing)* _____

City:_____ State:_____ Zip Code: _____

Home Phone:_____ Work Phone_____

Social Security Number:_____ Sex: • Male • Female Date of Birth: _____/_____/_____

Email Address:_____ Marital Status: *Married Single Divorced Widowed*

Employment Status: *Full Time Part Time Unemployed Student Retired*

Employer Name, Address: _____

Occupation:_____ Hobbies/Sports:_____

Referred By:_____ Last Eye Exam:_____ Dr. _____

Parent/Responsible Party Name, Address, Phone:_____

_____

Computer Use? • Yes • No How many hours per day? _____ Do you experience Computer Eye Strain? • Yes • No

Reason for visit today_____

INSURANCE

Do you have vision insurance? • Yes • No Insurance Company_____

Insured's ID #_____ Group #_____ Insured's Date of Birth _____/_____/_____

Insured's Place of Employment_____ Relation to Patient_____

GLASSES

Do you wear glasses? • Yes • No • Previous Wearer

When? • All the time • Occasionally • Reading • Driving • TV • Other How old are your glasses?_____

Have you had any problems with your glasses in the past?_____

CONTACTS

Are you interested in new Contact Lenses? • Yes • No Have you ever worn Contact Lenses? • Yes • No

What type are you wearing? • Hard • Gas Perm • Soft • Disposable • Astigmatism • Bifocal • Monovision

What brand of Contact are you wearing?_____ How long have you had this pair_____

Care System (Solution) _____ Ever had a reaction to drops or solutions? • Yes • No

Describe any problems you have with your contacts_____

MEDICATIONS

List medications you are currently taking, including eye drops, birth control, vitamins, or any non-prescription medications.

_____

ALLERGIES

List your allergies to medications or other substances.

_____

_____

Physician's Name_____ Last Physical Exam _____

Physician's Address _____

EYE HEALTH HISTORY *Circle all that apply to you.*

Bloodshot Eyes	Dry Eyes	Light Sensitive
Blurred Vision - Distance	Eye Infection	Loss of Vision
Blurred Vision - Near	Eye Injury	Migraine Headaches
Burning Eyes	Eye Strain	Night Vision Poor
Cataracts	Fainting Spells, Blackouts	Red Eyes
Color Vision Defect	Floaters / Spots	Seeing Halos
Crossed Eyes	Glaucoma	Seeing Flashes
Discharge from Eyes	Headaches	Temporary Loss of Vision
Dizzy Spells	Itching Eyes	Twitching Eyelid
Double Vision	Lazy Eye	Watering Eyes

GENERAL HEALTH & FAMILY HISTORY *Check all that apply to yourself and your family history.*

	Yourself	Family Member		Yourself	Family Member
Arthritis	☐	☐	High Cholesterol	☐	☐
Asthma	☐	☐	Kidney Disease	☐	☐
Blindness	☐	☐	Lazy Eye	☐	☐
Cancer	☐	☐	Lupus	☐	☐
Cataracts	☐	☐	Migraine Headaches	☐	☐
Diabetes	☐	☐	Pacemaker	☐	☐
Emphysema	☐	☐	Poor Color Vision	☐	☐
Epilepsy	☐	☐	Retinal Disease	☐	☐
Eye Surgery	☐	☐	Shingles	☐	☐
Glaucoma	☐	☐	Skin Conditions	☐	☐
Hay Fever	☐	☐	Stroke	☐	☐
Heart Condition	☐	☐	Thyroid Disorder	☐	☐
Hepatitis	☐	☐	Tuberculosis	☐	☐
High Blood Pressure	☐	☐	Turned Eye	☐	☐

DILATION OF PUPILS

We may need to dilate your pupils to examine the health of the inside of your eyes. This means you will be given drops that enlarge your pupils (the black circles inside your eyes). This is the best method to thoroughly examine all the structures and tissues inside your eyes. Dilation usually lasts 4 to 6 hours. You may experience some blurring, light sensitivity and difficulty reading during this time. Disposable sunwear is available at no charge.

OFFICE POLICIES

Payment for exam is expected at the time of service. We accept cash, personal checks, MasterCard, VISA, Discover, and Debit Cards. All glasses and contact lenses must be paid for in full when delivered, unless other arrangements have been made. We guarantee your satisfaction with our services and products.

The information in this document and your file are held confidential

Patient's Signature _____

(if patient is under 18, parent signature)

The practice:

(a) is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI;

(b) adheres to Ohio law in those instances where Ohio law does not conflict with federal law. See explanation of Ohio law, attached;

(c) is required to abide by the terms of this Privacy Notice;

(d) reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains;

(e) will distribute any revised Privacy Notice to you prior to implementation;

(f) will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is effective as of 04/15/03.

PATIENT ACKNOWLEDGEMENT

I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

Patient Signature _____

Date _____