NAME: _____DATE OF BIRTH: _____
MAILING ADDRESS: _____
TOWN: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ CELL: _____
SS#: _____ EMAIL: _____
OCCUPATION: _____ WORK PHONE: _____
MARITAL STATUS: [ ] MARRIED [ ] SINGLE [ ] OTHER _____
SMOKING HISTORY (PACKS PER DAY, LENGTH OF TIME): _____
FAMILY DOCTOR: _____ PHONE: _____

ANY EYE PROBLEMS OTHER THAN GLASSES, SUCH AS:
[ ] EYE PAIN [ ] VISION CHANGES [ ] REDNESS
[ ] BLURRINESS [ ] ITCHINESS [ ] DRYNESS

LIST CURRENT MEDICATIONS: _____
_____
ARE YOU ALLERGIC TO ANY MEDICATIONS? [ ] NO [ ] YES (PLEASE LIST)
_____

MARK ALL THAT APPLY- EMPTY BOXES WILL BE TAKEN AS *NEGATIVE*

[ ] UNEXPLAINED WEIGHT CHANGE
[ ] NOSE OR THROAT PROBLEMS
[ ] HIGH BLOOD PRESSURE
[ ] ASTHMA
[ ] HEPATITIS
[ ] CANCER _____
[ ] STROKE
[ ] HIGH CHOLESTEROL
[ ] MIGRAINES/SEVERE HEADACHES
[ ] ANEMIA
[ ] ANXIETY
[ ] DIABETES
[ ] HIV/AIDS
[ ] EMPHYSEMA/CHRONIC BRONCHITIS
[ ] UNEXPLAINED FATIGUE
[ ] HARD OF HEARING
[ ] HEART DISEASE
[ ] SKIN DISORDERS
[ ] STOMACH PROBLEMS
[ ] KIDNEY PROBLEMS
[ ] ARTHRITIS
[ ] PARKINSONS
[ ] MULTIPLE SCLEROSIS
[ ] ALLERGIES
[ ] DEPRESSION
[ ] THYROID DISEASE
[ ] ALZHEIMERS/DEMENTIA
[ ] FIBROMYALGIA
[ ] ANY MEDICAL PROBLEMS NOT LISTED ABOVE: _____

PLEASE MARK ALL THOSE THAT APPLY TO YOUR IMMEDIATE FAMILY: (MOTHER, FATHER, BROTHER, SISTER, OR GRANDPARENTS)

[ ] GLAUCOMA
[ ] DIABETES
[ ] CATARACTS
[ ] MACULAR DEGENERATION
OTHER GENERAL EYE PROBLEMS _____

<u>PLEASE SIGN AND DATE THE FIRST AVAILABLE LINE ON THE BACK****</u>**

PRIVACY POLICY

YOU ARE ENTITLED TO THE UTMOST IN PRIVACY REGARDING THE WAY YOUR MEDICAL INFORMATION AND YOUR RECORDS ARE HANDLED. YOU WILL BE GIVEN A COPY OF OUR UPDATED PRIVACY POLICY ON YOUR FIRST VISIT AFTER SEPTEMBER 23, 2013. AT ANY TIME AFTER THAT, IF YOU WOULD LIKE A COPY OF THE POLICY, PLEASE LET US KNOW.

PAYMENT AND/OR ASSIGNMENT OF BENEFITS

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING ALL COSTS ASSOCIATED WITH MY CARE AT FAMILY OPTOMETRY. IF I HAVE HEALTH INSURANCE, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE IN THE EVENT THAT ALL OR SOME OF THE PAYMENT IS DENIED OR NOT COVERED BY MY INSURANCE CARRIER OR OTHER THIRD PARTY PAYOR.

MANAGED CARE WAIVER

IF MY INSURANCE POLICY IS A MANAGED CARE POLICY, I REALIZE THAT I AM RESPONSIBLE FOR OBTAINING A REFERRAL FROM MY PRIMARY CARE PHYSICIAN. IF I HAVE NOT OBTAINED A REFERRAL, I WILL BE RESPONSIBLE FOR ALL CHARGES.

Patient or Guardian Signature	Date	Rev. By
Patient or Guardian Signature	Date	Rev. By
Patient or Guardian Signature	Date	Rev. By
Patient or Guardian Signature	Date	Rev. By
Patient or Guardian Signature	Date	Rev. By
Patient or Guardian Signature	Date	Rev. By
Patient or Guardian Signature	Date	Rev. By
Patient or Guardian Signature	Date	Rev. By