Welcome to Optometric Associates, PC. We appreciate your time in answering the questions on this form. Your overall health relates to your eye health so each section is important.
Thank you!

Updated: 1/1/2020

___Mr. ___Mrs. ___Miss. ____ Ms: ____Other:_____

________________________ _____ _______________________________ ___________________
First Name MI Last Name Preferred Name

____ _________________ _________________
Street Address City Zip Code

________________________ ________________ ___________________ Texting? YES / NO
Social Security Number Date of Birth Primary Phone Number

_________________________________ ______________________
Email Address Other Phone Number

_________ I consent to my glasses and/or contact lens prescription being e-mailed to me and I acknowledge it is not HIPPA compliant.
Initials

Emergency Contact: ______________________ Relationship: ________________ Phone:__________________
Name

PRIMARY INSURANCE:
Relation to Primary Insured: Self / Spouse / Child / Parent / Other: _______________________

Name of Insurance Company: _____________________________

Insurance ID Number: ______________________ Policy Holder's Name: _____________________

Date of Birth: __________________ Policy Holder's SSN (If Applicable): _____________________

SECONDARY INSURANCE:
Relation to Primary Insured: Self / Spouse / Child / Parent / Other: _______________________

Name of Insurance Company: _______________________ Insurance ID Number: __________________

Policy Holder's Name: _____________________ Date of Birth: _________ Policy Holder's SSN: ______________

HIPPA POLICY: Please read carefully.
I agree to allow my medical information be shared with my insurance company for the sole purpose of billing and to any healthcare provider necessary for continuity of care.
I acknowledge that I am aware that Optometric Associates, P.C. has a Notice of privacy practices available to me at all times during normal business hours. I fully understand that I am protected under HIPPA and will be required to sign a release for any and all medical records.

______________________________________ ________________________
Signature of Patient/Legal Guardian Date

OFFICE POLICY: Please read carefully.
In order to control the cost of billing we require that the patient's portion of costs is due at the time of services rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. All accounts with unpaid bills after 90 days are subject to collection fees. There will be a service charge on all returned checks. We require at least 24 hours notice for any cancelations or rescheduled appointments in order to be fair to our other patients. **Any late cancellations or missed appointments are subject to a $50 fee.** I acknowledge and accept the above policies.

____ ___________________________
Signature of Patient/Legal Guardian Date

RACE: (Circle all that apply): Asian / White / Hispanic (Latino) / Black (African American) / Native American /

Other: ______________________ / Declined to Specify

Preferred Language: English / Spanish / Chinese / French / Hindi

PRIMARY CARE PHYSICIAN: _______________________________ CLINIC NAME: ________________

____ ____________________

Office Address Phone Number

HEALTH HISTORY

Main Reason for Today's Exam: _______________________ Last Eye Exam: __________________

Last Physical Exam: __________________ Height: _______ Weight: _____ Are you pregnant or nursing? YES NO

Past Illnesses or Injury: __________________ ____

Past Surgeries: _____________________ _____________________ ______________________

Current Medications (Attach list if needed):

____

____

Current Eye Drops: ____

Allergies/Sensitivities to Medications: ____

Specific Allergies: ____

SOCIAL HISTORY

Current Occupation: _________________________ Years: ________ Employer: ______________

Do you: Smoke Cigarettes **YES** **NO** Drink Alcohol **YES** **NO** Other: ________________

MEDICAL HISTORY

	YES	NO		YES	NO
Do you have high blood pressure?			Blurry vision distance?		
A history of stroke?			Blurry vision near?		
Diabetes?			Floaters?		
HIV or AIDS?			A history of eye surgery?		
High cholesterol?			Have you ever had a retinal detachment?		
Thyroid condition?			Do you have amblyopia (lazy eye)?		
Asthma or lung problems?			Macular Degeneration?		
Arthritis?			Eye Pain?		
Other Medical Conditions? List Below			Dry, gritty or burning sensation of the eye?		
			A history of ocular trauma?		
			Do you have glaucoma?		

FAMILY HISTORY

Unknown ☐

	YES	NO
Macular Degeneration		
Glaucoma		
Color Blindness		
Blindness		
Retinal Detachment		
Diabetes		
Cancer		
High Blood Pressure		
Thyroid		
Other		

GLASSES HISTORY (Circle all that apply)

Have you ever worn glasses? YES NO **Do you currently wear glasses? YES NO**

If yes→ Type of glasses worn? Distance / Reading / Bifocals / Progressives (No Line Bifocal)

Have you ever worn contact lenses? YES NO **Do you currently wear contact lenses? YES NO**

If yes→ Brand/Type of contact lenses: ____