***Our doctor will not perform an exam on a patient under 18 years of age without a written or verbal consent of legal guardian.***

**Patient Information Today’s Date**

**Patient Name** (First, Middle, Last)

**Nickname** **Date of Birth** **Social Security Number**

**Gender** ( ) Male ( ) Female **Email**

**Street Address**

**City** **State** **Zip Code**

**Marital Status** ( ) Single ( ) Married ( ) Domestic Partner ( ) Widowed

**Home Phone** **Daytime Phone** **Cell Phone**

**Employer** **Occupation** **Work Phone**

**Emergency Contact/Guardian** **Relationship Phone Number**

**Referred by** ( ) Doctor ( ) Patient/Family/Friend ***Who may we thank?***

**Primary Insurance Information**

Vision Company ID#

Primary Insured Date of Birth SS#

Medical Company ID#

Primary Insured Date of Birth SS#

**Secondary Insurance Information**

Vision Company ID#

Primary Insured Date of Birth SS#

Medical Company ID#

Primary Insured Date of Birth SS#

**HIPAA**

The HIPAA policy can be viewed and/or obtained at the front desk. Please choose ONE of the following options:

( ) I have read or received a copy of the HIPAA policy and agree with statements within.

( ) I refuse to read or receive a copy of the HIPAA policy and therefore decline treatment from this physician.

I understand the HIPAA rights and agree with the guidelines within the policy. **Initials**

**Cancellation/No Show Policy**

Your appointment is especially reserved for you. We would greatly appreciate at minimum 24 hour notice of cancellation. I have been made aware that there may be a $35.00 fee if there is no notice given for cancellation. **Initials**

**Financial Statement**

I assume financial responsibility for any and all fees that may be incurred during my office visit. I understand that The Optical Shoppe, PLLC will file my insurance and may bill me for any fees not covered by my insurance plan. I understand that not all insurance companies will contribute to my refraction and agree to this fee if it is a non-covered expense. I hereby authorize The Optical Shoppe, PLLC employees to contact me for future appointments or expenses by phone, postal mail courier or email.

**Signature**  **Date**

**Physician Information**

**Last Optometrist** **Phone** **Last Exam**

**Glasses** ( ) Distance Only ( ) Reading Only ( ) Computer Only ( ) Progressive/Bifocal ( ) Safety/Occupational

**Contact Lens ( )** Yes ( ) No *Did you sleep in your contact lens prior to this exam? ( ) Yes ( ) No*

**Primary Care Physician** **Phone** **Last Exam**

**Last Known Height**  **Weight Blood Pressure** **A1c Blood Sugar**

**Medication and Medical Allergy**

*Please list ALL medications you are currently taking. If you brought a list in today we will be happy to scan it into your chart.*

**Medications**

**Medical Allergies** ( )No Known Drug Allergies

**Social History** ( )Current Smoker ( )Former Smoker ( )No Alcohol Use ( )Social Alcohol Use ( )Alcohol Dependent ( )Drug Dependent

***If Alcohol Dependent*** ( ) Current ( ) Former ***If Drug Dependent*** ( ) Current ( ) Former

**Chief Complaint**

( ) Blurry Distance ( ) Blurry Near ( ) Blurry Computer/Intermediate ( ) Double Vision ( ) Sudden Vision Loss

( ) Ocular Allergies ( ) Dryness ( ) Burning ( ) Redness ( ) Pain {1-10} ( ) Itching

( ) Flashes of light ( ) Floaters/Spots ( ) Foreign Body ( ) Eyelid Twitching ( ) Turned/Lazy Eye ( ) Headaches

( ) Glaucoma ( ) Cataracts ( ) Macular Degeneration ( ) Retinal Detachment ( ) Other

**Health History**

**Eye Surgery** ( ) PRK/Lasik ( ) Eye Muscle ( ) Cataract ( ) Glaucoma ( ) Retinal

**Allergy** ( ) Seasonal ( ) Skin ( ) Food

**Cardiovascular** ( ) Hypertension ( ) Atrial fibrillation ( ) Pacemaker ( ) Heart Disease ( ) Elevated Cholesterol

**Ear/Nose/Throat** ( ) Hearing Loss ( ) Hearing Impaired ( ) Bad Breath ( ) Tinnitus/Vertigo ( ) Meniere's Disease

**Endocrine**  ( ) Diabetes ( ) Hormone Condition ( ) Thyroid ( ) Graves’ disease ( ) Hashimoto's ( ) Adrenal Condition

**Gastrointestinal** ( ) Acid Reflux ( ) Heartburn ( ) Irritable Bowel Syndrome ( ) Crohn’s Disease ( ) Colitis

**Genitourinary** ( ) Pregnant ( ) Lactating ( ) Enlarged Prostate ( ) Erectile Dysfunction ( ) Kidney Stones

 **Immunologic** ( ) HIV/AIDS ( ) Sickle Cell ( ) Anemia ( ) Sjögren syndrome ( ) Cancer

**Musculoskeletal** ( )Arthritis ( )Rheumatoid Arthritis ( )Back/Neck Pain ( )Fibromyalgia ( )Down’s Syndrome ( )Muscular dystrophy

**Neurological** ( ) Migraines ( ) Seizure Disorder ( ) Alzheimer's ( ) Cerebral palsy ( ) Multiple sclerosis ( ) Parkinson's

**Psychiatric** ( )ADD/ADHD ( )Autism ( )Anxiety/Depression ( )Insomnia ( )Schizophrenia/Personality Disorder ( )Dementia

**Respiratory** ( ) Asthma ( ) COPD ( ) Tuberculosis ( ) Emphysema ( ) Oxygen Dependent

Please list any medical conditions not listed above

**Family History**

( ) Hypertension ( ) Diabetes ( ) Glaucoma ( ) Macular Degeneration ( ) Retinal Defects