Patient Information

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. (Please Print)

Name _____ Birthdate _____ Age _____
FIRST MI LAST

Address _____ City _____ State _____ Zip _____

Social Security #_____ Home Phone (____)_____ Cell Phone (____)_____

Employer _____ Occupation _____ Work Phone (____)_____

Spouse's or Parent's name _____ Please circle preferred communication: Text Email Phone

E-Mail_____ *(ENABLES US TO SEND APPT REMINDERS, VISION INFO, OFFICE PROMOS)*

Whom may we thank for referring you to us? Doctor/Optician - Yellow Pages - Newspaper _____

Do you currently see any other Optometrist or Ophthalmologist? If so, who _____

Health History

Reason for today's exam _____ Date of last exam _____

Please check any of the following that apply to you:

☐ Diabetes ☐ Blindness ☐ Asthma ☐ High Blood Pressure ☐ Eye Disease
☐ Cataracts ☐ Thyroid ☐ Allergies ☐ Turned or lazy eye ☐ Drug Allergies
☐ Glaucoma ☐ Heart Disease ☐ Sinus Trouble ☐ Frequent Headaches ☐ Pregnant

Do you use cigarettes or tobacco? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No

Does anyone in your immediate family have a history of the following?

☐ Cataracts ☐ Eye Disease ☐ Macular Degeneration ☐ Diabetes ☐ High Blood Pressure
☐ Glaucoma ☐ Blindness ☐ Retinal Detachment ☐ Heart Disease ☐ Other _____

Family Physician _____ Address _____

Please list all medications you are currently taking: _____

_____

Have you ever had any of the following conditions involving your eyes?

☐ Eye surgery ☐ Eyes burn, itch, or water ☐ Poor distance vision ☐ Floaters or spots
☐ Eye injury ☐ Sensitivity to light ☐ Poor near vision ☐ Eye infection or disease
☐ Eye strain ☐ Severe pain ☐ Double vision ☐ Medical treatment

Do you currently wear glasses? ☐ Yes ☐ No – If yes, when do you wear your glasses?

☐ All the time ☐ Reading/near work ☐ Work Safety
☐ Distance tasks only ☐ Computer work ☐ Other, please explain _____

Have you ever worn contacts? ☐ Yes ☐ No – If yes, what style?

☐ Soft ☐ Gas Permeable ☐ Extended Wear ☐ Disposable
☐ Bifocal ☐ Tinted ☐ Astigmatic ☐ Unsure

Are you interested in wearing contact lenses? ☐ Yes ☐ No

Do you work at a computer or video display terminal? ☐ Yes ☐ No

Are you interested in Laser Vision Correction? ☐ Yes ☐ No

What sports or hobbies do you participate in? _____

Insurance Information

Responsible Party _____ Relationship to patient _____

Insured's Date of Birth _____ Social Security # _____

Address if Different _____ City _____ State _____ Zip _____

Type of insurance (please check one)

EYEMED Med Ben/ Vision Plus AETNA

VSP (Vision Service Plan) Other _____

Insurance Company _____ Insured ID# _____

Group # _____ Plan # _____

Do you have additional insurance? Yes No – IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____

Insurance Company _____ Insured ID# _____

Insurance Co. Address _____ City _____ State _____ Zip _____

Group # _____ Plan # _____

AGREEMENT

CONSENT: I certify that I have read and answered the questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to take video, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a through diagnosis of the patient's vision needs. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners.

FEES: Fees for services are due at the time of service. This is inclusive of examinations, prescriptions, and visual training sessions. A 50% deposit is required on eyewear and some contacts ordered, with the balance due on receipt of the eyewear.

INSURANCE: All fees are due at the time of service. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance benefits payments; however, the patient is responsible for all charges. (Exclusions to this are EYEMED, VISION PLUS, VSP and CARE CREDIT.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or guardian if a minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOCAL POINTE OPTOMETRY

*You may refuse to sign this acknowledgement

I, _____, have received a copy of Focal Pointe Optometry's Notice of Privacy Practices.

Please Print Name _____

Please Sign Name_____

Today's Date_____