# EyeWish Optometry

"You will see the difference"

**Welcome to our office!** Please fill out the following. Your responses will be treated as confidential medical information.

**Name (Last, First, M.I.)**_____

**Sex** □ Male □ Female □ _____

**DOB (MM/DD/YY)** _____

**Home address** _____

**City** _____ **State** _____ **Zip** _____

**Phone (_____)**_____ Home □ or Cell □

**Email address** _____

**How do you prefer to be contacted?**

□ Home □ Cell □ Email

**How did you learn about our office?** _____

**Vision Insurance**:

Name of Insured : _____

□ None □ EyeMed □ VSP

Insured's DOB ____ / _____ / _____ SSN ___ ___ ___ ___

Relationship to insured**:**

□ Self □ Spouse/Partner □ Child □ Other

**Is the Billing Address Different?** □ Yes □ No

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Medical Insurance**

Plan Name: _____

□ PPO □ HMO

Name of Insured (Last, First) _____

Insured Date of Birth _____

ID # _____ Group #_____

**Emergency Contact**:

Name_____

Phone (_ _ _)_____

Relationship to patient _____

## Eye and Medical History

**What is the reason(s) for your visit here today?**

_____

**Do you currently wear glasses?** □ Yes □ No

**Would you rather not wear glasses?** □ Yes □ No

## Contact Lens Wearers Only

**Brand of contacts worn in the past** _____

**Which type? (Check one)** □ Soft □ Gas Perm. □ Other

**Do you experience any eye symptoms?**

_____

_____

**Have you ever had any eye injuries or surgeries to your eyes? If yes, please list and indicate which eye(s) and the approximate date(s).** □ Yes □ No

_____

_____

**Who/where is your primary care doctor or internist? When was your last physical exam with your primary care doctor?**

_____

_____

**Are you pregnant or nursing?** □ Yes □ No

**Do <u>you</u> or any of <u>your relatives</u> have any of the following?**

- Glaucoma?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Cataracts?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Macular Degeneration?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Retinal Disease/Detachment?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Blindness?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Strabismus (eye turn)?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Diabetes?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Cancer?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Heart Disease?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Hypertension?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- High Cholesterol?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

- Thyroid Condition?
□ **Self** □ **Mother** □ **Father**
□ **Sibling** □ **Grandparent**

**Do you use tobacco products?** □ Current □ Former □ Never

**Do you drink alcohol?** □ Socially □ Yes □ No

**Please list all of the medications including eyedrops you are currently taking, both prescription and over the counter:**

_____

_____

_____

**Do you have any <u>allergies to medications</u>?** □ Yes □ No

**If yes, please list:**

_____

**Do you have any other allergies?** □ Yes □ No

If yes, please list here:_____

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**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

The law requires that **EyeWish Optometry** make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that **(PLEASE CHECK ONLY ONE):**

- ❑ I have read or had explained to me **EyeWish Optometry's** Notice of Privacy Practice and agree to continue my care with **EyeWish Optometry** under said terms.
- ❑ I was given the opportunity to read **EyeWish Optometry's** Notice of Privacy Practices and declined but wish to continue my care with **EyeWish Optometry** under the terms of **EyeWish Optometry's** privacy policies.
- ❑ I have read or had explained to me **EyeWish Optometry's** Notice of Privacy Practice and do not wish to continue my care with **EyeWish Optometry** under said terms.
- ❑ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as:

_____

- ❑ I **DO** authorize EyeWish Optometry to release my medical diagnoses to my vision plan
- ❑ I **DO NOT** authorize EyeWish Optometry to release my medical diagnoses to my vision plan

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient_____ Date_____

If you are signing as a personal representative of the patient, please indicate your relationship

Representative_____ Relationship to Patient_____