PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

Patient's Authorization to Release Medical Information

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the phone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way without my expressed written consent. By signing this form, I am designating the parties below to be able to discuss my medical condition with *O'Hara Vision Center*.

I understand this form will not be updated every calendar year. If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform *O'Hara Vision Center* in writing of my decision.

Name of Patient: _____

In accordance with the above I, _____, hereby authorize O'Hara Vision Center to discuss with and release my medical information to the following:

_____ _____

_____ _____

The below individuals are authorized to pick up any written prescriptions, glasses or contact lens prescriptions on my behalf:

_____ _____

_____ _____

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by state what information is to be excluded:

Patient or responsible party signature: _____

Date: _____ Witness: _____

DEMOGRAPHICS:

I, _____, hereby state the information read to me regarding my current address, phone number, and insurance provider is correct and up to date.

I, _____ (or my dependent), certify to have insurance coverage with _____. I assign directly to *O'Hara Vision Center* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure payment of PATIENTS AUTHORIZATION TO RELEASE MEDICAL INFORMATION.

I, _____, understand it is a breech of physician-patient confidentiality for my doctor to release my medical information in any way without my written consent. I understand it is my responsibility to update this information at each visit.

If you have someone you would like to add as an authorized user, please notify the front desk at this time. If no authorized users are noted, your records cannot be discussed or released with anyone other than yourself.

WARRANTY: I understand all prescriptions are under 30-day warranty. And, in the event of a refund, there will be 30% return fee due to *O'Hara Vision Center* at the time of the return.