Welcome

Thank you for choosing our practice for your eye care needs. If you have any questions or concerns, do not hesitate to ask for assistance.

Patient Information

Today's

Name _____ Date_____ SS # _____
First MI Last

Address _____ City _____ State _____ Zip _____

Birth date _____ Home Phone # (_____) _____ Work Phone # (_____) _____

Do you prefer to receive calls at: ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Any #** ☐ **Texts Ok** Cell Phone **# (____) _____**

Are you: ☐ **Minor** ☐ **Married** ☐ **Single** ☐ **Widowed** Are you: ☐ **Male** ☐ **Female**

Have you seen our television commercial? ☐ **Yes** ☐ **No**

You or your parent's employer _____Occupation_____

If you are a student, name of school/college _____ Grade _____

Whom may we thank for referring you to us? _____

Person to contact in case of Emergency _____ Phone # _____

Email address_____

Insured Information &/or Responsible Party (*If other than yourself*)

Person insured &/or responsible for this account? _____ **Birthdate** _____

Relationship to patient _____ **Social Security #**_____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____Work Phone # _____

Reason for today's exam:

☐ Other:_____

☐ Poor distance vision
☐ Severe pain
☐ Blurred vision
☐ Eye Strain
☐ Poor near vision
☐ Eyes hurt
☐ Dry eyes
☐ Eyes burn, itch, or water
☐ Glare or haze while driving

Date of last exam _____

Name of eye doctor _____

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Health History

Name_____Age_____

FAMILY HISTORY: Does anyone in your immediate family have a history of the following? Relation?

☐ Diabetes Type_____/R:___ ☐ High Blood Pressure_____ ☐ Blindness_____
☐ Thyroid _____ ☐ Turned or lazy eye_____ ☐ Glaucoma_____
☐ Heart condition_____ ☐ Macular Degeneration_____ ☐ Retinal Detachment _____
☐ Other _____

PATIENT HISTORY: Have you ever been diagnosed with any of the following:

☐ Diabetes Type_____ ☐ High Blood Pressure_____ ☐ Blindness_____
☐ Thyroid _____ ☐ Turned or lazy eye_____ ☐ Glaucoma_____
☐ Heart condition_____ ☐ Macular Degeneration_____ ☐ Retinal Detachment _____
☐ Other _____

Please list all medication(s) you are currently taking: Check if none ☐ _____

_____

Allergies to medications:_____

What is your general health? _____

Name of your family Doctor: _____

Do you currently smoke tobacco? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No

When do you wear your glasses?

☐ All the time ☐ Reading/near work ☐ Work safety ☐ Computer work
☐ Distance tasks only ☐ Other, please explain_____

Have you ever worn contacts? ☐ Yes ☐ No

If so, what style? ☐ Soft ☐ Extended wear ☐ Gas Permeable ☐ Bifocal
☐ Tinted ☐ Astigmatic ☐ Disposable ☐ Unsure

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

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

What hobbies or sports do you participate in? _____

Doctor's Review_____ Date___/___/_____

Doctor's Review_____ Date___/___/_____

Consent and Authorization

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the use or disclosure of my protected health information by TSOC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of TSOC. I understand that diagnosis or treatment of me by the doctor may be conditioned upon my consent as evidenced by my signature. I authorize my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Written Acknowledgement of Doctor's Notice of Privacy Practices:

I _____, acknowledge that I have received a copy of Tri-State Optical
(Please print first and last name)
Center's Notice of Privacy Practices, and I agree with the Consent and Authorization stated above.

X_____ _____

*SIGNATURE OF PATIENT DATE

*If other than patient's signature, please describe relationship to patient: _____

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