WELCOME TO OUR OFFICE!

Adult Form

PATIENT INFORMATION

Today's Date: ____________________

Last Name: ____________________

First Name: ____________________ MI: ________

Address: ____________________

City: ____________________

State: ____________________ Zip: ________

Home Phone: ____________________

Work/Day Phone: ____________________

Cell Phone: ____________________

Gender: M F Date of Birth: ____________________

Patient SSN: ____________________

Marital Status: ____________________

Employer: ____________________

Occupation: ____________________

How would you prefer to receive announcements or newsletters?

☐ Email ☐ Mail ☐ Twitter ☐ Not at all

Email/Twitter: ____________________

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

☐ Another doctor/patient—who? ____________________

☐ Insurance list/insurance website

☐ Internet—which website? ____________________

☐ Magazine ad—which one? ____________________

☐ Yellow Pages—which one? ____________________

☐ Other: ____________________

PRIVACY PRACTICES FOR HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Opticology Eyecare's statement on privacy practices.

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Opticology Eyecare to release any medical or incidental information that may be necessary for medical benefit or to obtain payment for services. This includes but is not limited to vision plans or medical insurances.

CONSENT FOR TREATMENT: I/We hereby authorize Opticology Eyecare to administer diagnostic and medical procedures as may be necessary for proper health care.

____

Patient Signature Date

LIFESTYLE QUESTIONS

Are you planning on purchasing glasses today?

☐ Yes ☐ No ☐ Maybe

Are you planning on getting a contact lens evaluation today?
(Additional fees apply.)

☐ Yes ☐ No ☐ Maybe

Do you...? *(Check all that apply)*

☐ wear prescription glasses?

☐ have ultraviolet protection sunwear?

☐ have "back up" prescription eyewear?

☐ wear contact lenses?

If so, what kind? ____________________

Solution used: ____________________

☐ experience discomfort with your contacts?

☐ work at a computer? ________ hrs/day

☐ have interest in a non-surgical approach to vision correction?

☐ want information on LASIK surgery?

☐ have children?

What are your hobbies? ____________________

____

What specific problems do you have with your vision, eyes, glasses, or contact lenses? ____________________

____

____

DILATION CONSENT

Dr. Barger and the American Optometric Association recommend a dilated eye examination to fully assess the health of your eyes. With dilation, drops are placed in the eyes to enlarge the pupils so that the doctor can carefully examine you for eye disease. Dilation is routine and does not cost extra.

Dilation will cause sensitivity to light and will make your near vision temporarily blurry. Our office will provide you with disposable sunglasses to minimize your sensitivity.

If you have any questions, the Doctor will be happy to answer them. Please INITIAL one option below, indicating that you have read and understood the dilation consent.

___ Yes, I consent to have my eyes dilated today.

___ No, I do not wish to have my eyes dilated today, but I will reschedule the dilation.

___ No, I do not consent to have my eyes dilated, and I agree to hold the practice harmless as a result.

____

Patient Signature

OPTICOLOGY EYECARE

The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT EYE HISTORY

Date of last eye exam: ______

Previous eye doctor: ______

Have you ever experienced, been diagnosed, or been treated for any of the following? (Check all that apply.)

	Currently	In the Past
Blurry vision without glasses/CLs	☐	☐
Blurry vision with glasses/CLs	☐	☐
Vision loss	☐	☐
Corneal abrasions	☐	☐
Allergy	☐	☐
Double vision	☐	☐
Eye turn/crossed eye	☐	☐
Floaters/spots	☐	☐
Flash of light	☐	☐
Foreign body	☐	☐
Headaches	☐	☐
Pain/irritation	☐	☐
Red eye	☐	☐
Eye injury/trauma	☐	☐
Eye fatigue/tired Eyes	☐	☐
"Lazy eye"/amblyopia	☐	☐
Difficulty reading	☐	☐
Sensitivity to light	☐	☐
Dry eye	☐	☐
Itchy/burning eyes	☐	☐
Watery eyes	☐	☐
Eye infections	☐	☐

Other eye problems: ______

______

FAMILY MEDICAL/ EYE HISTORY

Have you or a family member been diagnosed with any of the following? Please check all that apply.

	Self	Family member (which?)
Blindness	☐	☐
Cataracts	☐	☐
Cornea problems	☐	☐
Eye turn	☐	☐
Glaucoma	☐	☐
Macular degeneration	☐	☐
Retinal problems	☐	☐
Heart disease	☐	☐
Diabetes	☐	☐

PATIENT MEDICAL HISTORY

Primary physician: ______

Location: ______

Date of last physical exam: ______

Current Medications (Rx or over-the-counter):
(List all medications including eye drops, vitamins, etc.)

______

______

Allergies to medications? ☐ Yes ☐ No

If so, what medications? ______

______

Have you had any surgeries? ☐ Yes ☐ No

If so, please describe: ______

______

Is there a possibility that you are pregnant? ☐ Yes ☐ No

Do you use: ☐ Tobacco ☐ Alcohol ☐ Other substances

Have you ever been diagnosed or treated for the following health problems? (Check all that apply.)

- ☐ Allergies
- ☐ High blood pressure
- ☐ Cholesterol
- ☐ Cardiovascular
- ☐ Anemia
- ☐ Headaches/ migraines
- ☐ Sinus problems
- ☐ Ear, nose, throat
- ☐ Endocrine
- ☐ Digestive
- ☐ Kidney
- ☐ Reproductive
- ☐ Genitourinary
- ☐ Blood/lymph
- ☐ Immune system
- ☐ STD
- ☐ Skin/eczema/rashes
- ☐ Diabetes
- ☐ Arthritis
- ☐ Muscle/bone
- ☐ Neurological
- ☐ Psychiatric
- ☐ Asthma
- ☐ Respiratory
- ☐ Cancer

Other health problems: ______

______

______

Did you know that some medical conditions and medications could affect your vision?

Your health history is important in evaluating your current and future eye health.