

# Welcome!



v2.5.11

## Patient Information

Date: \_\_\_\_\_

Sex:  Male  Female

Name: \_\_\_\_\_ → Preferred Name: \_\_\_\_\_  
First Name Last Name

Address: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

City: \_\_\_\_\_

Social Sec #: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Employer: \_\_\_\_\_  Student

Single  Married  Divorced  Widowed

Occupation: \_\_\_\_\_

Home phone: \_\_\_\_\_

Alt. phone: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Emergency phone #: \_\_\_\_\_

◆ **If this is your first visit to our office, whom can we thank for referring you?** \_\_\_\_\_

## Financial & Insurance Information

Who is responsible for payment? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

Birth date: \_\_\_\_\_

City: \_\_\_\_\_

Insurance: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Member #: \_\_\_\_\_

Home phone: \_\_\_\_\_

Group #: \_\_\_\_\_

Work phone: \_\_\_\_\_

## Eye Health History

Name of last eye doctor: \_\_\_\_\_

Do you wear glasses?  Yes  No

Approximate date of last eye exam: \_\_\_\_\_

Do you currently wear contacts?  Yes  No

Have you had LASIK?  Yes  No

◆ If no, are you interested in contacts?  Yes  No

Check the box if you have recently experienced or been diagnosed with any of the following **with** your glasses or contacts:

- |                           |                          |                             |                          |
|---------------------------|--------------------------|-----------------------------|--------------------------|
| Bloodshot eyes            | <input type="checkbox"/> | Floaters or spots in vision | <input type="checkbox"/> |
| Blurred vision – distance | <input type="checkbox"/> | Glaucoma                    | <input type="checkbox"/> |
| Blurred vision – near     | <input type="checkbox"/> | Migraine headaches          | <input type="checkbox"/> |
| Burning in eyes           | <input type="checkbox"/> | Headaches                   | <input type="checkbox"/> |
| Cataracts                 | <input type="checkbox"/> | Itching eyes                | <input type="checkbox"/> |
| Crossed eyes              | <input type="checkbox"/> | Light sensitivity           | <input type="checkbox"/> |
| Discharge from eyes       | <input type="checkbox"/> | Poor color vision           | <input type="checkbox"/> |
| Dizzy spells              | <input type="checkbox"/> | Poor night vision           | <input type="checkbox"/> |
| Double vision             | <input type="checkbox"/> | Red eyes                    | <input type="checkbox"/> |
| Dry eyes                  | <input type="checkbox"/> | Seeing flashes of light     | <input type="checkbox"/> |
| Eye infection             | <input type="checkbox"/> | Seeing halos                | <input type="checkbox"/> |
| Eye injury                | <input type="checkbox"/> | Temporary loss of vision    | <input type="checkbox"/> |
| Eye strain                | <input type="checkbox"/> | Twitching eyelid            | <input type="checkbox"/> |
| Fainting spells           | <input type="checkbox"/> | Watering eyes               | <input type="checkbox"/> |

**- Please turn over and complete other side -**

**Health History**

Name of general practitioner or doctor: \_\_\_\_\_

Check the appropriate box if you or any blood relatives have had any of the following medical conditions:

<input type="checkbox"/> Check here if adopted	Yourself	Blood relatives		Yourself	Blood relatives
	<input type="checkbox"/>	<input type="checkbox"/>	ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition or Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Cancer – type: _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Retinal disease	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye or amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Poor color vision	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Eye injury / surgery – please list ↴	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal condition	<input type="checkbox"/>	<input type="checkbox"/>
			AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
			Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>
			Shingles	<input type="checkbox"/>	<input type="checkbox"/>
			Skin condition – type: _____	<input type="checkbox"/>	<input type="checkbox"/>
			Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>
			Rheumatoid arthritis or Lupus	<input type="checkbox"/>	<input type="checkbox"/>
			Autism	<input type="checkbox"/>	<input type="checkbox"/>
			Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
			Mental condition: _____	<input type="checkbox"/>	<input type="checkbox"/>
			Depression	<input type="checkbox"/>	<input type="checkbox"/>
			Asthma	<input type="checkbox"/>	<input type="checkbox"/>
			Emphysema or COPD	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>
			Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>

Other pertinent health information: \_\_\_\_\_

Do you smoke?  Yes  NoDo you drink alcohol?  Yes  No**Medications**List any medications you currently take, including eye drops:  None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any allergies to medications or other substances that you have:  None

\_\_\_\_\_

\_\_\_\_\_

**Authorization, Financial Policy & HIPAA Statement**

I authorize Drs. Steve and Stacey Beck to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eye care to third party payers for the purpose of payment, and/or health practitioners until otherwise requested in writing. I assign all insurance benefits, if any, to Drs. Beck otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Optix Optometry requires payment in full for examination fees and all materials at the time of service or ordering. We accept cash, checks, money orders, Visa, Master Card and Discover. An overdraft fee of \$25.00 will be assessed for returned checks. Client(s) will be responsible for any balances owed. If balances are not paid, the client will be responsible for all collection agency fees and attorney fees totaling 200% of the account balance.

Contact lens examinations may be subject to a contact lens fitting fee with one free follow-up appointment. All other contact lens checks or follow-up appointments may include additional fees.

*"I have read the Optix Optometry HIPAA Notice of Privacy Policy posted either on the web site or in the office waiting area."*

*"I have read the contents of this page and understand by signing my name, I agree to all of the terms and conditions."*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_