PATIENT INFORMATION **Today's Date:** ________________________

Last Name: ____ **First Name:** ____ **M or F**

Name Preference: ______________________________ **DOB:** _________/______/__________ **SSN:** _________ -_______ -___________

Address: ____ **City** __________________________ **ST** ____ **Zip** _____________

Phone Number: ______________________________ **Email Address:** ____

Primary Care Physician: ____ Height: _____________ Weight: _____________

Reason for Today's exam ____ Are you Pregnant? Y / N Nursing? Y / N

Occupation: ____ Hobbies: ____

Medical (check & list)	**Self**	**Medications - List Names**	**Relative - List Relationship**
Diabetes [Type 1 / Type 2]	YES / NO		
High Blood Pressure	YES / NO		
Cholesterol	YES / NO		
Heart Disease	YES / NO		
ADHD	YES / NO		
Alzheimer's	YES / NO		
Arthritis	YES / NO		
Asthma	YES / NO		
Autism / Asperger's	YES / NO		
Behavioral / Psychiatric	YES / NO		
Cancer (list type)	YES / NO		
Headaches / Migraines	YES / NO		
Herpes / Shingles	YES / NO		
HIV / AIDS	YES / NO		
Seizures	YES / NO		
Thyroid [Hyper / Hypo]	YES / NO		
Other Not Listed	YES / NO		
Allergies to Medications?	YES / NO		

Ocular (check & list)	**Self**	**Medications - List Names**	**Relative - List Relationship**
Glaucoma	YES / NO		
Macular Degeneration	YES / NO		
Dry Eye	YES / NO		
Eye Surgery / Lasik	YES / NO		
Eye Allergies	YES / NO		
Other Not Listed			

Do you use tobacco products? NO YES If Yes: Type: _________________ Amount ________________ For How Long ______________

Do you drink alcohol? NO YES If Yes: Type: _________________ Amount ________________ For How Long ______________

Do you use illegal drugs? NO YES If Yes: Type: _________________ Amount ________________ For How Long ______________

Do you currently wear glasses? Y / N / readers **Will you be updating your glasses today? Y / N / unsure**

Do you wear contacts? Y / N - INTERESTED in contacts or RENEWING your CL Rx today? Y / N - Are you WEARING CONTACTS today? Y / N

*** Dilation or OPTOS is <u>REQUIRED</u> for a full health examination and a complete eye exam. ***

Dilation side effects include light sensitivity and blurred vision for up to 6 hours. **PLEASE CIRCLE YOUR CHOICE AND SIGN:**

I would like OPTOS ($39) / I would like to dilate **Signature** ____________________________________

HIPAA STATEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly or indirectly. 2) Obtain payment from third party payers. 3) Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ______________________________________Date: ___________________________