Optic Gallery Family Eye Care

Patient Information

First visit Y/N

Name:______________________________ Today's Date:______/______/______

Date of Birth:______________________ Age:________ SS #:______________________

Address:______________________________

City:______________ State:________ Zip:________

Phone:______________ Cell:______________ Email:______________________

Place of Employment/School:______________________ Occupation:______________________

Date of last eye exam:______________________ By whom:______________________

Do You Wear Contact Lenses: Y/N If so, which type/brand:______________________

How did you hear about us:______________________

Reason for today's visit, please list concerns:______________________

Medical History

Name of medical doctor:______________________ Phone#:______________________

Date of last visit:______________________ Are you pregnant or nursing Y/N

Do you: ☐ Smoke type/amount/how long______________________

☐ Drink type/amount/how long______________________

☐ Use drugs type/amount/how long______________________

Height__________ Weight__________ Race__________ Preferred Language______________

List of medications and **dosage**:______________________

Medical allergies:______________________

Do you have any of the following: ☐ I have no known medical conditions

☐Headaches/Migraines	☐High Blood Pressure	☐Diabetes
☐Seizures	☐Heart Disease	☐Loss of Vision
☐Psychiatric Disorder	☐High Cholesterol	☐Double Vision
☐Sinus Congestion	☐Rheumatoid Arthritis	☐Flashes/Floaters
☐Emphysema	☐Joint/Muscle Pain	☐Cataracts
☐Asthma	☐Thyroid Dysfunction	☐Glaucoma
☐Cancer	☐Anemia	☐Macular Degeneration
☐Immune Disorder	☐Bleeding Disorder	☐Eye Surgery______________________
☐HIV	☐Kidney Disorder	☐Other______________________

Family History

Please note any family history including parents, grandparents, siblings, children; living or deceased and **specify relationship**

☐Blindness	☐Cancer	☐Lupus	☐Diabetes
☐Cataracts	☐Macular Degeneration	☐High Blood Pressure	☐Heart Disease
☐Glaucoma	☐Retinal Disease	☐Kidney Disease	☐Other______________________

Insurance/Guarantor Information

Name:______________________ Relationship:______________________

Date of Birth:______________________ SS #:______________________

Employer:______________________ Work phone:______________________

Health Insurance:______________________ Policy #:______________________

Vision Insurance:______________________ Policy#:______________________

In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, I authorize Optic Gallery to do so. If applicable, I hereby authorize that payment by my insurance company be made directly to Optic Gallery for any services rendered to me. I also authorize Optic Gallery to release any information that is required to process a claim for services rendered.

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE COMPANY.

Signature (Patient or Guardian):______________________ Date:______________________