/ / ____ / / ____ **Welcome to Our Office** / / ____ / / ____
/ / ____ / / ____ / / ____ / / ____

Patient Name (please print) ____

If a Child, Parent's Name ____

Street Address ____

City ________________________ State ______ Zip Code __________________

Home Phone _____________________ Work Phone _________________ X ____

Cell Phone _____________________ E-mail ___________________________

Birth Date ___________ M or F SSN: ________________ Marital Status □ Single □ Married □ Other

What is your occupation? _____________________ Who is your employer? _____________________

Spouse's Employer ____________________ Work Phone _______________________

Vision Insurance Carrier __________________ Policy ID Number _____________________

Relationship to Insured □ Self □ Spouse □ Parent
Name of Person (Other than Self) ______________ DOB______

Health Insurance Carrier __________________ Policy ID Number _____________________

Relationship to Insured □ Self □ Spouse □ Parent
Name of Person (Other than Self) ________________ DOB______

If Medicare, Secondary Insurance Carrier________________ Policy ID Number ______________

How did you find out about our office? ____

What is the main reason for today's exam? ______________________________________

This is to certify that I, the undersigned, hereby consent to authorize the disclosure of any medical or other information necessary for a referral to another doctor or insurance company. (We will disclose only that information that is necessary.)

I also authorize the disclosure of information to the following: (Check All That Apply)
□ **Husband** □ **Wife** □ **Children:(Names)**____________________________________

□ **Parents** □ **Grandparents** □**Other – please specify:**_____________________________

____

Name of Medical Doctor ______________ Dr.'s Phone ____________ Last Medical Exam ______________

Last Eye Exam(If not performed here) ____________ Where was the eye exam performed? ________________

May we leave a message on your answering machine with medical, appointment, or insurance information?
□Yes □ No

We send recall post card reminders when it is time for your next appointment. Is that ok?
□ Yes □ No
If you do not want a specific disclosure made to the above (allowed) list, please notify our office. Thank you for your cooperation.
A statement of our privacy policies is available on our website at: http://joelpways.com/privacynotice.html or available upon request.

Medications

Do you take any medications? □ Yes □ No If yes, please provide us with a list, or list them below. Please include oral contraceptives, aspirin, over the counter medications, vitamins & supplements, and home remedies:

Name	Dosage	How Often?
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________
____________________________	___________	___________

Past/Present Ocular History

Do you ever have or have ever had any of these ocular (eye) problems? If Yes, please check box

□Crossed Eyes	□ Lazy Eye	□ Drooping Eyelid	□ Retinal Disease	□ Cataracts
□ Eye Infections	□ Eye Injury	□ Macular Degeneration	□ Itching	□ Burning
□ Redness	□ Blurred Distance Vision	□ Blurred Near Vision	□ Loss of Vision	□ Loss of Side Vision
□ Double Vision	□ Distorted Vision/Halos	□ Mucous Discharge	□ Tired Eyes	□ Dryness
□ Sandy or Gritty Feeling	□ Foreign Body Sensation	□ Excess Tearing/ Watering		□ Glaucoma
□ Glare/Light Sensitivity	□ Eye Pain or Soreness	□ Headaches	□ Chronic Infection of Eye or Lid	
□ Sties or Chalazion	□ Sudden Onset of Flashes		□ Retinal Detachment	
□ Fluctuating Vision	□ Floaters (Constant or Sudden Onset)		□ Color Blindness	

Social History

What are your hobbies? ____

On average how many days per a week do you use a computer ________ And how many hours per day ___________

Do you wear glasses? □ Full Time □ Part Time □ No If yes, do you wear them for: □ Distance □ Reading □ Both

Do you wear Contacts? □ Yes □ No □ No, but I want them If yes, do you: □ sleep in them □ wear monovision contacts □ wear bifocal contacts

How long have you been wearing contacts _______ years

Do you use tobacco products? □Every Day Smoker □ Some Day Smoker □ Chewing Tobacco □ Former Smoker □ Never a Smoker
If yes, Type/Amount? _________________________ How long have you been smoking? ________________

Do you drink? □ Socially □ 3 or less times per week □ 4 or more times per week □ No

Do you use illegal drugs? □ Yes □ No If yes, type/amount/how long: ____

Review of Systems

Constitution
- □ Fatigue
- □ Fever
- □ Sudden Weight Loss
- □ Sudden Weight Gain
- □ ____________________

Cardiovascular
- □ Angina
- □ Arrhythmia
- □ Bypass Surgery
- □ Congestive Heart Failure
- □ Coronary Artery Disease
- □ High Cholesterol
- □ History Of Heart Disease
- □ Hypertension Controlled
- □ Hypertension Uncontrolled
- □ Irregular Heart Beat
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Shortness Of Breath
- □ Stent
- □ Stroke
- □ Valve Replacement
- □ ____________________

Ear, Nose, & Throat
- □ Chronic Sinusitis
- □ Chronic Strep Infections
- □ Hearing Aid □ R □ L
- □ Hearing Loss □ R □ L
- □ Nose Bleeds
- □ Ringing In Ears
- □ Sinus Pain
- □ ____________________

Respiratory
- □ Asthma
- □ COPD
- □ Bronchitis
- □ Chronic Bronchitis
- □ Chronic Cough
- □ Emphysema
- □ Lung Cancer
- □ Pneumonia
- □ Sarcoid
- □ Shortness Of Breath
- □ Tuberculosis
- □ ____________________

Gastrointestinal
- □ Bowel Cancer
- □ Change In Appetite
- □ Crohn's Disease
- □ Colitis
- □ Gall Bladder Disease
- □ Gastric Reflux
- □ GERD
- □ Hepatitis Type □ A □ B □ C
- □ Jaundice
- □ ____________________

Genitourinary
- □ Bladder Repair
- □ Dialysis
- □ Kidney Failure
- □ Kidney Transplant
- □ Ovarian Cancer
- □ Prostate Cancer
- □ STD
- □ Testicular Cancer
- □ ____________________

Musculoskeletal
- □ Arthritis
- □ Cerebral Palsy
- □ Gout
- □ Juvenile Rheumatoid Arthritis
- □ Multiple Sclerosis
- □ Muscle Pain
- □ Muscular Dystrophy
- □ Polymyalgia
- □ Rheumatoid Arthritis
- □ ____________________

Integumentary
- □ Allergy Shots
- □ HIV
- □ Immune Disorder
- □ Lupus
- □ Seasonal Allergies
- □ ____________________

Neurological
- □ Bell's Palsy
- □ Cranial Nerve Palsy
- □ Dizziness
- □ Epilepsy
- □ Involuntary Movement
- □ Migraines
- □ Paralysis
- □ Seizures
- □ Stroke
- □ TIA
- □ Vertigo
- □ ____________________

Psychiatric
- □ Depression
- □ Dementia
- □ Mood Swings
- □ Nervousness
- □ Panic Episodes
- □ Paranoia
- □ ____________________

Endocrine
- □ Diabetes □ Type 1 □ Type 2
- □ Gestational Diabetes
- □ Prediabetes
- □ No Current Treatment
- □ Adrenal Gland Disorders
- □ Hypoglycemia
- □ Hyperthyroidism
- □ Hypothyroidism
- □ ____________________

Hematologic/Lymphatic
- □ Anemia
- □ Blood Disorders
- □ Hemophilia
- □ Enlarged Lymph Nodes
- □ Leukemia
- □ Lyme Disease
- □ Lymphoma
- □ ____________________

Allergic/Immunologic
- □ ASA
- □ Beta Blockers
- □ Codeine
- □ E-mycin
- □ Fluorescein
- □ Novocain
- □ Penicillin
- □ Sulfa
- □ Tetracycline
- □ Bees
- □ Cats
- □ Dairy Products
- □ Dogs
- □ Mites
- □ Mold
- □ Mydriatics
- □ Narcotics
- □ Pollen
- □ Thiomersal
- □ Yeast
- □ ____________________

Surgeries (What Type and When) ____

____

____

____

Family History

	Mom	Dad	PatGF	PatGM	Mat.GF	Mat.GM	Sibling	Aunt	Uncle	Cousin
Amblyopia (Lazy Eye)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cataract(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Color Blindness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus (Eye Turn)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other (List Type and Relation) ____

____

Payment Policy:
We will do all we can to find out what your vision insurance benefits are and for what you are eligible. We will also submit your claim for you. The information given to us by your insurance company is not a guarantee of payment from them. If your insurance company does not pay this amount, **it will be your responsibility to pay your balance.**

To the best of my knowledge, the above information is correct.

Patient or Responsible person: ___________________________________Date_________________