Buckeyecare Optometrists Patient Information Form

Name:_____ **Preferred nickname:**_____

If a minor: Parents' or guardians' names_____

If a minor: Who is financially responsible (to whom should we send any bills)? _____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Email address:_____ **We will not give your email to anyone.**

How you prefer we contact you (please circle): Text msg Phone call Email

May we send exam summaries and appointment reminders to your email address? Yes No

May we leave messages on your home answering machine and/or cell voicemail? Yes No

Home phone:_____**Cell phone:**_____**Work phone:**_____

Birthdate:_____ **Marital status:**_____ **Last 4 digits of SS #:**_____

Person to call in case of emergency_____

Their phone number:_____ **Relationship to you:**_____

Who can we thank for sending you to us?_____

Primary Care Physician Name and Mailing Address _____

_____

We will not discuss any aspects of your care/conditions/orders with any other person or family members (with the exception of parents/guardians of minor children). Please list any names of people, including family members, you would like us to be able to discuss these matters with.

Name:_____ **Relationship to you:**_____

Name:_____ **Relationship to you:**_____

Insurance and Financial Policy

I request that payment of any authorized insurance benefits for any services furnished to be made on my behalf to Buckeyecare Optometrists. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges not paid by the insurance plan or any balance due if I fail to supply correct or up to date insurance information before my visit. I also understand that I am responsible for all collection fees if my account is past due over 90 days.

Please sign:_____ **Date:**_____

Current Vision Information

Occupation/Grade:_____ Employer/School: _____

Business Address:_____

City:_____ State:_____ Zip:_____

Approximate date of last eye exam with an eye doctor:_____
The eye doctor's name (or company name):_____
Do you wear glasses?_____ If so: full-time / close work / distance / computer
Do you wear contacts?_____ If so: most of the time / occasionally
Are you interested in discussing contacts today (usually an additional fee)?_____
Are you interested in discussing refractive surgery (including LASIK)?_____

How many hours a day on a computer?____ smart phone____ TV____ driving____

Please circle any hobbies you participate in:

Racquet Sports	Motorcycling	Gardening	Crafting	Woodworking
Volleyball	Biking	Yardwork	Reading	Painting
Soccer	Walking	Birding	Card Playing	Shopping
Baseball	Running	Fishing	Puzzles	Gambling
Basketball	Hiking	Swimming	Music	Other: _____
Football	Skiing	Golf	Video Games	_____

Parental/Guardian Consent for Dilation of a Minor's Eyes

For patients under age 18:
During the course of an eye examination, it may be helpful to dilate the eyes to gain a more detailed view of the inside of the eye. Dilation involves instilling eye drops in the eyes that temporarily increase the size of the pupil (the black center of the eye). These drops can cause temporary light sensitivity and blurred vision primarily for reading that generally lasts for serveral hours. I heareby give permission for my child's eyes to be dilated at the doctor's discretion today and during the course of future appointments. If at any time I do not want my child's eyes dilated, verbal communication of this to the examining doctor will be honored.

Parent/guardian's signature:_____

Name (please print) :_____

Patient Name:_____Date of Birth:_____Today's Date:_____

History (Do you have any history of the following?)

YES	NO	
___	___	Cancer, if yes, please list_____
___	___	Lung Disease (e.g. Asthma, COPD, etc.), if yes, please list_____
___	___	Kidney Disease If yes, are you on dialysis?_____
___	___	Arthritis - If yes, have you been told you have Rheumatoid Arthritis? _____yes _____no
___	___	Diabetes - If Diabetic, What type?_____ # of years diagnosed_____
___	___	Thyroid Disorder, if yes, please list type_____
___	___	Neurological Disease, if yes please list type_____
___	___	Migraines, if yes when were you diagnosed?_____
___	___	Head or Spinal Injury, if yes, when and how?_____
___	___	Seizures, Convulsions, or Fainting, if yes please list_____
___	___	Any Nervous or Psychiatric Disorder, if yes please list_____
___	___	Heart Disease, if yes please list_____
___	___	Gastrointestinal Disease, if yes please list_____
___	___	High Blood Pressure, if yes please state how many years treated_____
___	___	High Cholesterol, if yes please state how many years treated_____
___	___	Carotid Artery Disease, if yes please list any surgery/date_____
___	___	Skin Disease, if yes please list_____
___	___	Stroke, if yes when?_____
___	___	Are you pregnant or nursing?_____
___	___	Immune Disorder, if yes please list_____
___	___	Urinary or Genital Disease, if yes please list_____
___	___	Permanent Defect from Illness/Disease/Injury, if yes what?_____
___	___	Recent Unexplained Weight Loss/Gain or Fever, if yes please list_____

Surgical History (Please list all surgeries and date, including eye surgeries such as LASIK or cataract surgery)

1._____2._____3._____4._____

5._____6._____7._____8._____

Your Ocular History (Have you been diagnosed with any of the following?)

YES	NO	
___	___	Cataracts-If you had surgery, date of surgery and which eye_____
___	___	Retinal Disease, if yes, list any surgery_____
___	___	Eye Muscle Problems, if yes, list any_____
___	___	Iritis, if yes, when diagnosed/how often_____
___	___	Corneal Disease, if yes, please list/dates_____
___	___	Glaucoma, if yes when diagnosed_____
___	___	Any other type of eye injury, if yes, when and how?_____
___	___	Macular degeneration, if yes, when diagnosed/any surgeries?_____

Please list ALL medications you are currently taking, INCLUDING vitamins, non-prescription medications, and birth control.

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Please list any medications you are allergic to:

1. _____ 2. _____ 3. _____ 4. _____

Please list all EYE medications you are currently using, INCLUDING any non-prescription eye drops

1. _____ 2. _____ 3. _____ 4. _____

Please list any eye drops you are allergic to:

1. _____ 2. _____ 3. _____ 4. _____

Please list all other allergies (e.g. cats, dogs, foods, pollen). List specific seasons for seasonal allergies.

1. _____ 2. _____ 3. _____ 4. _____

Social History

YES	NO	
___	___	Have you ever smoked?
		If you are a current smoker, how many cigarettes/packs daily or weekly?_____
		If you are a current smoker, how many years have you smoked?_____
		If you quit smoking, how many years ago did you quit?_____
___	___	Do you drink alcohol frequently? If yes, how many drinks daily/weekly?_____
___	___	Do you drink infrequently or socially (less than once a week)?

Family History

Does anyone in your family (blood relative) have any of the following? Please note relation to patient: F-Father, M-mother, S-Sister, B-Brother, U-Uncle, A-Aunt, C-Cousin, GF-Grandfather, GM-Grandmother. <u>Specify P-Paternal (father's side) or M-Maternal (mother's side).</u>

YES	NO		YES	NO	
___	___	Glaucoma_____	___	___	Retinal Detachment_____
___	___	Cataracts_____	___	___	Macular Degeneration_____
___	___	Diabetic Retinopathy_____	___	___	Other Eye problems_____
___	___	Retinitis Pigmentosa_____	___	___	Diabetes_____
___	___	Corneal Disease_____	___	___	Heart Condition_____
			___	___	Stroke_____