

Name:
Account#:

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Home Phone: _(_____) Work: _(_____) Cell:_(_____)

Preferred Contact#: Home Work Cell Marital Status: Sing Mar Div Wid Sep

SSN: _____ DOB: _____ Sex: M F

Preferred Language: English Spanish Other _____

Street Address/City/State/Zip: _____

Billing Address: _____

Email Address: _____ Employer/Occupation: _____

Full Time Resident? Y N If No, Other Address: _____

Primary Care Physician: _____ Address: _____

Who Can We Thank For Referring You To Our Practice:

- | | |
|--|--|
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Social Media | <input type="checkbox"/> Doctor: _____ |
| <input type="checkbox"/> Website | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Employer | |

GUARANTOR OR RESPONSIBLE PARTY: Self (Patient) Other (If Patient Is Minor)

If Other, Last Name: _____ First Name: _____ MI: _____ Suffix: _____

Home Phone: _(_____) Work: _(_____) Cell:_(_____)

DOB: _____ Relationship To Patient: _____

EMERGENCY CONTACT (Other than telephone number listed above)

Name: _____ Relationship To Patient: _____

Home Phone: _(_____) Work: _(_____) Cell:_(_____)

PRIMARY MEDICAL INSURANCE

Company: _____ ID#: _____ Group#: _____

Policyholder Name: _____ DOB: _____ Relationship To Patient: _____

SECONDARY MEDICAL INSURANCE

Company: _____ ID#: _____ Group#: _____

Policyholder Name: _____ DOB: _____ Relationship To Patient: _____

VISION INSURANCE

ID#: _____ Group#: _____ Policyholder Name: _____

DOB: _____ Relationship To Patient: _____

PATIENT MEDICAL HISTORY

NAME: _____

DATE: _____

Please check YES or NO if you have or ever had any of the following:

- | | | | | | |
|----------------------------|----------------------------|---|----------------------------|----------------------------|---|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer - Type _____ | <input type="checkbox"/> Y | <input type="checkbox"/> N | High Cholesterol |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Taken Flomax / Hytrin / Cardura | <input type="checkbox"/> Y | <input type="checkbox"/> N | Thyroid Disease |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | High Blood Pressure | <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes – <input type="checkbox"/> Oral <input type="checkbox"/> Diet <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Stroke / CVA | <input type="checkbox"/> Y | <input type="checkbox"/> N | GERD |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Disease / Murmur | <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney Disease |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Attack | <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney Stones |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Congestive Heart Failure | <input type="checkbox"/> Y | <input type="checkbox"/> N | Liver Disease |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Irregular Heartbeat / Palpitations | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hepatitis – <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y | <input type="checkbox"/> N | Auto-Immune Disease – Type _____ |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | COPD | <input type="checkbox"/> Y | <input type="checkbox"/> N | Infectious Diseases _____ |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Migraines | <input type="checkbox"/> Y | <input type="checkbox"/> N | Dementia / Memory Loss |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Arthritis | <input type="checkbox"/> Y | <input type="checkbox"/> N | MRSA |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Sleep Apnea - Use a CPAP? <input type="checkbox"/> Y <input type="checkbox"/> N | | | |

Have you received a pneumonia vaccine? Y N

Have you ever smoked? Y N - Do you still smoke? Y N

Do you drink alcohol? Y N - Daily Occasionally Rarely

SURGERIES

Please check the box if you have had any of the surgeries listed below:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> No Surgical Procedures | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Prostate | <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> LASIK / RK |
| <input type="checkbox"/> Heart Stints | <input type="checkbox"/> Colostomy | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Cornea Transplant |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Glaucoma Procedure |
| | | | <input type="checkbox"/> Eyelid Procedure |

OTHER EYE DIAGNOSIS

Have you been diagnosed with any of the following eye diseases/disorders:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Corneal Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Amblyopia / Lazy Eye | <input type="checkbox"/> Other _____ |

ALLERGIES

Yes – Please list below No Known Allergies Latex Allergy? Yes No

MEDICATIONS

Please list any medications you take, prescription or over the counter; You may provide a list if available:

FAMILY HISTORY

Do you have any FAMILY history of:

(Mother, Father, Siblings, Grandparents)

- | | | | |
|----------------------|----------------------------|----------------------------|------------|
| Diabetes | <input type="checkbox"/> Y | <input type="checkbox"/> N | Who: _____ |
| Glaucoma | <input type="checkbox"/> Y | <input type="checkbox"/> N | Who: _____ |
| Macular Degeneration | <input type="checkbox"/> Y | <input type="checkbox"/> N | Who: _____ |
| Blindness | <input type="checkbox"/> Y | <input type="checkbox"/> N | Who: _____ |
| Adopted/Unknown | <input type="checkbox"/> Y | <input type="checkbox"/> N | |

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REVIEW OF SYSTEMS

NAME: _____ DATE: _____

Please check all that apply to your **current** and **past** health.
Boxes that are not checked will be considered a negative response.

General / Constitutional

- Overall Healthy
- Weight Loss / Gain
- Fatigue
- Fever and Chills
- Weakness

Integumentary (Skin)

- Skin Cancer
- Rash
- Bruising
- Suspicious growths
- Itching

Ears/Nose/Mouth/Throat

- Dry Mouth
- Sinus Pain / Infections
- Ringing in ears
- Vertigo
- Wears hearing aids

Respiratory

- COPD
- Asthma
- Emphysema
- Oxygen use
- Shortness of Breath

Cardiovascular

- Chest Pain
- Hypertension
- Heart attack
- Heart Surgery
- Palpitations

Gastrointestinal

- Heartburn / Acid reflux
- Diverticulitis
- Nausea
- Hernia
- Ulcers

Musculoskeletal

- Arthritis
- Back pain
- Swelling of joints
- Stiffness
- Muscle pain / joint pain

Neurological

- Memory Loss
- Headaches
- Parkinson's disease
- Seizures
- Tremors

Endocrine

- Diabetes
- Hyperthyroidism
- Hypothyroidism
- Frequent Urination
- Excessive thirst

Psychiatric

- Anxiety
- Depression
- Stress

Allergies / Immunological

- Allergic reaction to medications
- Allergic reaction to foods
- Seasonal / Environmental allergies
- Autoimmune disease

Other conditions or medical problems not listed?:

X

Patient Signature

Date

X

Parent or Guardian Signature

Date

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Name: _____ Date: _____ Acct#: _____

VISUAL ASSESSMENT FORM AND LIFESTYLE QUESTIONNAIRE

Occupation: _____

Hobbies: _____

Circle the degree of difficulty you have doing the following activities because of your vision.

Functional Vision Assessment

Circle One

Would you like to be less dependent on glasses??	Distance	Near	Both	
Difficulty seeing street signs or driving (curbs, highway exits, traffic lights, halos/glare in lights)	No	Mild	Moderate	Severe
Difficulty seeing TV or movies (faces, numbers, printing)	No	Mild	Moderate	Severe
Difficulty reading small print with glasses (books, newspaper, pill bottles, instructions, cell phone)	No	Mild	Moderate	Severe
Difficulty performing detailed work (sewing, threading a needle, baiting a hook)	No	Mild	Moderate	Severe
Difficulty with personal correspondences (writing checks, reading bills, filling out forms)	No	Mild	Moderate	Severe
Difficulty with leisure activities (playing cards, bingo, bowling, golfing)	No	Mild	Moderate	Severe
Difficulty functioning around the house (cooking, general household upkeep, stairs, telephone)	No	Mild	Moderate	Severe
Difficulty recognizing faces of people (church, grocery store, clubs, other daily activities)	No	Mild	Moderate	Severe

Please circle the activities you would prefer to do with less dependence on glasses:

- | | | | | |
|---------------------------|---------------------------|----------------------|-----------------------|--------------------|
| Reading | Seeing pill bottles | Looking at a menu | Looking at your watch | Using a cell phone |
| Card or table games | Sewing | Applying makeup | Using a computer | |
| View dashboard of car | Seeing price tags/shelves | Shopping | Bingo | Driving |
| Playing sports, like golf | Watching TV | Watching live sports | Going to movies | Swimming |

X _____
Patient Signature

Date

X _____
Parent or Guardian Signature

Date

<p>ATTENTION: If you speak English or American Sign Language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-469-886-0419 or speak to your provider.</p>
<p>ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-469-886-0419 o hable con su proveedor</p>
<p>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-469-886-0419 an oder sprechen Sie mit Ihrem Provider.</p>
<p>注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-469-886-0419 或咨询您的服务提供商。</p> <p>注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-469-886-0419 或與您的提供者討論。</p>
<p>LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-469-886-0419 hoặc trao đổi với người cung cấp dịch vụ của bạn.</p>
<p>ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-469-886-0419 ou parlez à votre fournisseur.</p>
<p>ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-469-886-0419 или обратитесь к своему поставщику услуг.</p>
<p>تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (1-469-886-0419) أو تحدث إلى مقدم الخدمة.</p>
<p>주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-469-886-0419 번으로 전화하거나 서비스 제공업체에 문의하십시오.</p>
<p>PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-469-886-0419 o makipag-usap sa iyong provider.</p>
<p>ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-469-886-0419 o parla con il tuo fornitore.</p>
<p>ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòm aksèsib yo disponib gratis tou. Rele nan 1-469-886-0419 oswa pale avèk founisè w la.</p>
<p>ማሳሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጾች ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-469-886-0419 ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።</p>
<p>सावधान: यदि तपाईंनेपाली भाषा बोल्नुहुन्छ भनेतपाईंका लादि िनःशल्क भाषिक सहायता सेवाहरू उपलब्ध छन्।</p>

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<p>पहुँचुनु चयोग्य ढाँडुनु चाहरूमा जानकारी दरान दुननउपयुक्त सहायता र सेवाहरू पिन िदनि: शुल्क उपलब्ध छन्। 1-469-886-0419 मा फोन दुनुनहोस्वा आफ्नो दरायकसुदु करा दुनुनहोस्।</p>
<p>MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-469-886-0419 au zungumza na mtoa huduma wako.</p>
<p>ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬ ਬੋਲਿੰਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਧਿਓ ਜਾਣਕਾਰ ਪਰਿਠ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੁਰਕ ਸਹਾਇਕ ਸਾਠਿ ਅਤੇ ਸੇਵਾਵਾਂ ਵ ਮੁਫਤ ਧਿਓ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-469-886-0419 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪਰਿਠਾ ਨਾਲ ਗਿੱਲ ਕਰੋ।</p>
<p>注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-469-886-0419 までお電話ください。または、ご利用の事業者にご相談ください</p>
<p>توجه: اگر [وارد کردن زبان] صحبت میکنید، خدمات پشتیبانی زبان رایگان در دسترس شما قرار دارد. همچنین کمکها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالبهای قابل دسترس بهطور رایگان موجود میباشند. با شماره 1-469-886-0419 تماس بگیرید یا با ارائهدهنده خود صحبت کنید.</p>
<p>LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-469-886-0419 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.</p>
<p>ATENÇÃO: Se você fala [inserir idioma], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-469-886-0419 ou fale com seu provedor.</p>
<p>ध्यान िः: यदि आप दहंिी बोलते हैं, तो आपके दलए दनि: शुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ रारूपों में जानकारी रिान करने केदलए उपयुक्त सहायक साधन और सेवाएं भी दनि: शुल्क उपलब्ध हैं। 1-469-886-0419 पर कॉल करें या अपने रिाता से बात करें।</p>
<p>UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) lub porozmawiaj ze swoim dostawcą</p>
<p>মনোনোগদি : দি আপদ বোংলো বনল তোহনল আপের জ য দব োমুনলয ভোষো সহোয়তো পদরনষবোদি উপলব্ধ রনয়নে। অ্যানেসন োগষ ফরমযোনে তথ্য প্রিনান র জ য উপ ুক্ত সহোয়ক সহন োদগতো এবাং পদরনষবোদিও দব োমুনলয উপলব্ধ রনয়নে। 1-469-886-0419 ষনর কল করু অ্থো আপের প্রিপা কোরীর সোনথ কথ্ো বলু ।</p>
<p>قابل رساے فارمیٹس می معلومات فراہم کرنے اگر آپ اردو بولتے ہی، تو پ کے ل ی زبان کی مفت مدد کی خدمات دستیاب ہی۔ توجه دین: پرکال کریں یا اپے فراہم کنندہ سے بات کریں۔ 1-469-886-0419 کے ل ی مناسب معاون امداد اور خدمات بھی مفت دستیاب ہی۔</p>