

Ammons Perry Optometric

Today's Date _____

Patient Information

Last Name _____

First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex M F

Patient's SSN _____

Ethnicity: (Optional) African American

American Indian Asian Hispanic/Latino

Native Hawaiian/Other Pacific Islander White Other

Home Phone _____

Work Phone _____

Cell Phone _____ May we text you Yes No

Email (Please include an email address so we can begin confirming appointments via email)

May we leave you voice mails Yes No

Employer _____

Occupation _____

School Name _____

Grade _____

Spouse or Parent(s) Name _____

Spouse or Parent(s) Work _____

Are you having any problems with your current eyeglasses/contact lenses? Yes No

If Yes, please explain:

Patient Medical History

Family Physician _____

Address _____

Phone _____

Pharmacy _____

Location _____

Phone _____

Have you ever been diagnosed or treated for the following health problems?

Fatigue Syndrome

Ulcer

Cancer

Acid Reflux

Developmental Disorder

Prostate Disease

Laryngitis

Kidney Disease

Sinusitis

Muscular Dystrophy

Hearing Loss

Arthritis

Multiple Sclerosis

Fibromyalgia

Stroke

Eczema

Epilepsy

Thyroid

Depression

Diabetes

High Blood Pressure

Blood Loss

Vascular Disease

Ulcer

Congestive Heart Failure

Anemia

Asthma

Environmental Allergies

Emphysema

Rheumatoid Arthritis

Bronchitis

Other

Latex Sensitivity

Current Medications: (RX or over the counter) List name of medications including eye drops, vitamins & birth control

Allergies to Medications Yes No

If yes, what medications are you allergic to?

Patient Eye History

Date of Last Eye Exam _____

By Whom _____

Do you wear: Eyeglasses Contact Lenses

If contacts, what kind are you currently using?

What type of solution are you using?

Are you satisfied with the vision and comfort of your contact lenses?

Yes No

Would you prefer clear contact lenses or colored contact lenses?

Clear Colored

If eyeglasses, and are wearing bifocals, do the lines or head tilting bother you? Yes No

Have you ever experienced, been diagnosed or treated for any of the following?

- Eye Surgery Patching
- Glaucoma Glaucoma Suspect
- Macular Degeneration Eye Injury
- Lazy Eye Burning
- Inflammatory Disorder Floaters/Spots
- Retinal Degeneration Double Vision
- Retinal Hole Occasional Dryness
- Cataract Trouble Seeing at Night
- Sunlight/Light Sensitivity

Family History

Is there a family medical history of any of the following?

(Check all that apply)

Please list family member:

- Thyroid _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Cancer _____
- Lazy Eye _____
- Cataract _____
- Glaucoma _____
- Retinal Problems _____
- Macular Degeneration _____
- Blindness _____
- Corneal Problems _____

Do you use alcohol? Yes No

Do you use tobacco? Yes No

Tobacco Use: Cigarettes Cigars
 Other Smokeless Tobacco

The Optomap is a retinal scan to analyze the present health issues of the eyes and monitoring in future years. The cost is \$32.50 and is most likely not covered by your vision care insurance. Please check this box if you would like a digital Optomap performed of your eyes.

____ (Please Initial) I hereby acknowledge that I have been provided with a copy of the "Notice of Privacy Practices" (HIPAA Privacy Act) of Elite Eye Care OD PLLC for my own records.

I, the undersigned, certify that I (or my dependent) have insurance coverage with and assign directly to Elite Eye Care OD PLLC, all insurance benefits if any, otherwise payable to me for services rendered. I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature

Date