The Eye Site, PC

Welcome to our practice! We appreciate your choosing us for your eye health care. Please complete the following; All information is strictly confidential.

Patient Information

Patient Name: _____
Address: _____ City: _____
State: ____ Zip: _____ Birthday: _____ Social Security #: _____
Phone: Home _____ Work _____ Cell _____
May we text you? __ Yes __ No Email: _____
Employment/ School: _____
Occupation: _____ Hobbies: _____
Whom may we thank for referring you to us? _____

Responsible Party

Person Responsible for Bill: _____ Date of Birth: _____
Relationship to Patient: _____
Medical Insurance: _____ Policy #: _____
Vision Insurance: _____ Policy #: _____
Insured's Social Security #: _____ Employer: _____
Relationship to patient: _____

Financial and Privacy Policy

I understand that I am personally responsible for payment of services and materials not covered by my medical/ vision insurance and agree to do so. **Fees are due the day the services are performed**. For materials, 50% is required before ordering, and the balance is due before delivery. I authorize The Eye Site, PC/ Stephanie Ommen, OD to release any medical/ vision insurance information necessary to process my claims and/ or aid in further care of my health. I agree that my signature on this form will cover all medical/ vision services rendered until such authorization has been revoked in writing by me. I understand that any activities performed after dilation are my own risk and responsibility, and I will in no way hold responsible The Eye Site, PC/ Stephanie Ommen, OD. I agree that a photocopy of this form may be used in lieu of the original. I agree to and acknowledge the receipt of the financial and privacy policies, the full copies of which are available upon request in writing from The Eye Site, PC.

I consent for The Eye Site, PC to disclose my protected health information to the following individuals, who are also allowed to pick up my materials:

_____ _____
_____ _____

_____ _____
Signature of Patient/ Representative Date

Patient Ocular and Medical History

Patient Name: _____ Male ___ Female ___
Last Eye Exam: _____ Doctor: _____ Location: _____
Reason for today's visit: _____

Personal Medical History:
Review of Systems:
Do you currently have or ever had any of the following? If so, please circle & list details:

Eyes:
Blurred Vision? _____
Dryness? _____
Watering? _____
Itching/ burning? _____
Redness? _____
Discharge? _____
Glare/ Light Sensitivity? _____
Eye pain/ strain? _____
Double Vision? _____
Cataracts? _____
Glaucoma? _____
Retinal Detachment? _____
Eye Turn? _____
"Lazy Eye"? _____
Macular Degeneration? _____
Eye Injury? _____
Flashes? _____
Floaters? _____
Loss of vision? _____
Other? _____

Constitutional:
Weight gain/ loss? _____
Fatigue/ Weakness? _____
Other? _____

Ear, Mouth, Nose, Throat:
Sinus? _____
Dry Mouth? _____
Other? _____

Lymphatic/ Hematologic:
Anemia? _____
Other? _____

Psychological:
Other? _____

Vascular:
Diabetes? _____
High Blood Pressure? _____
High Cholesterol? _____
Heart Disease? _____
Other? _____

Gastrointestinal:
Chron's? _____
Other? _____

Endocrine:
Thyroid Disease? _____
Other? _____

Genitourinary:
Bladder/ Kidney? _____
Other? _____

Neurological:
Nerve Condition? _____
Seizures? _____
Stroke? _____
Headaches? _____
Other? _____

Respiratory:
Asthma/ Ephysema? _____
Other? _____

Musculoskeletal:
Arthritis? _____
Other? _____

Skin:
Rosacea? _____
Other? _____

Cancer? _____

Allergies: Any medication allergies: Yes __ No __ Details _____
Any seasonal/ food/ other allergies: Yes __ No __ Details _____

Major Hospitalizations/ Surgeries: _____
Eye Injuries/ Surgeries: _____

Medications: Please list prescriptions and over-the-counter drugs, herbals, and eye drops

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Social History:
Do you drive? Yes __ No __
Have you ***ever*** used Tobacco: No ___
Yes: Former Smoker : Date quit: _____
Yes: Current Smoker: Details (Type/ Quantity): _____
Alcohol Usage: Yes__ No __ Details (Type/ Quantity): _____
Other Drug Usage: Details (Type/ Quantity): _____

Family Medical History:
Has anyone in your immediate family ever been diagnosed with: If so, who?
Macular Degeneration? _____ Diabetes? _____
Glaucoma? _____ High Blood Pressure? _____
"Lazy Eye"?_____ Thyroid? _____
Cataract? _____ Cancer? _____

What is your preferred language, if not English? _____
Race? _____ Ethnicity? _____
Height? _____ Weight? _____

Primary Care Doctor: _____ Phone: _____
Pharmacy: Medical Arts____ Mr. Discount____ Other:_____

Vision Needs:
Do you plan to update your glasses? Yes __ No __
If so, are you interested in glasses that change in the sunlight? Yes __ No __
Are you interested in contact lenses? Yes__ No__
Do you currently wear contacts? Yes __ No __
If so, what brand? _____
Are you happy with your comfort/ vision? Yes __ No __ Details: _____
Do you have back-up glasses? Yes ___ No ___
Do you want to do contact lenses at this visit? Yes ___ No ___
Do you use computers/ tablets/ smartphones? If so, how many hours daily? _____