**OPTOMETRIC ASSOCIATES OF WARREN COUNTY, P.C.**

(Patient)

**Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MI**:\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_ **ZIP**: \_\_\_\_\_\_\_

**Patient Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SSN**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please indicate (circle) type **Home**  **Cell Work**

**Alternate/ Emergency Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Who? \_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guarantor Information: (who is financially responsible for the bill)**

Self: \_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Address (if different from above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor Date of Birth \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Guarantor phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

**Please list any medications you take on a regular basis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you allergic to any medications? Y/N (**please list**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who is your Medical Dr? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last medical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you take medication for or been diagnosed with any of the following:** (check all that apply)

**High Blood Pressure \_\_\_\_\_ Migraines \_\_\_\_\_ Double Vision \_\_\_\_\_**

**High Cholesterol \_\_\_\_\_ Cataracts \_\_\_\_\_ Strabismus (turned eye) \_\_\_\_\_**

**Diabetes (Type 1 or 2) \_\_\_\_\_ Frequent Headaches \_\_\_\_\_ Amblyopia (lazy eye) \_\_\_\_\_**

**Thyroid Condition \_\_\_\_\_ Head Trauma \_\_\_\_\_ Prism in your glasses \_\_\_\_\_**

**Asthma or Lung issues \_\_\_\_\_ Glaucoma \_\_\_\_\_ Watery/Burning Eyes \_\_\_\_\_**

**Stroke History \_\_\_\_\_ Floaters \_\_\_\_\_ Gritty/Sandy feeling Eyes \_\_\_\_\_**

**Thyroid Condition \_\_\_\_\_ Retinal Detachment \_\_\_\_\_ Ocular Trauma \_\_\_\_\_**

**Arthritis \_\_\_\_\_ Macular Degeneration \_\_\_\_\_ Eye Surgery**(list) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Surgeries? Year?**

**I acknowledge that the Privacy Policy of Optometric Associates is available to me upon request and that my information will not be shared without my consent.**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family History**  (Immediate family members of patient)

Glaucoma \_\_\_\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Macular Degeneration \_\_\_\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retinal Detachment \_\_\_\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blindness \_\_\_\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of Vision \_\_\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High Cholesterol \_\_\_\_\_\_ Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Personal Health History & Symptoms** (please check all that apply to the patient)

**Do you currently use Cigarettes/Tobacco? Y/N Have you used Cigarettes/Tobacco in the past? Y/N**

**Do you consume Alcohol? Y/N (**please circle one) **On Occasion Socially Daily**

**Other Substances? Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eyes Respiratory Blood/Lymph nodes**

Previous Surgery **O** Yes **O** No Cough **O** Yes  **O** No Bruise Easily **O** Yes **O** No

Contact Lens Wear **O** Yes **O** No Congestion  **O** Yes **O** No Gums Bleed Easily **O** Yes **O** No

Eye Pain **O** Yes **O** No Wheezing **O** Yes **O** No Prolonged Bleeding **O** Yes **O** No

Double Vision **O** Yes **O** No Asthma  **O** Yes **O** No Heavy Aspirin Use **O** Yes **O** No

Glaucoma **O** Yes **O** No Chronic Bronchitis **O** Yes **O** No Anemia **O** Yes **O** No

Cataracts **O** Yes **O** No Emphysema **O** Yes **O** No

Macular Degeneration **O** Yes **O No Gastrointestinal Musculoskeletal**

Dry Eyes **O** Yes **O** No Heartburn **O** Yes **O** NoStiffness **O** Yes **O** No

Flashes **O** Yes **O** No Nausea/Vomitting **O** Yes **O** No Arthritis **O** Yes **O** No

**Floaters O Yes O No Jaundice/Hepatitis O Yes O No Joint Pain/Swelling O Yes O No**

Blurred Vision **O** Yes **O** No

**Ear, Nose, Throat Genital-Urinary Skin**

Hard of Hearing **O** Yes **O** No Pain/Difficulty **O** Yes **O** No Rash/Sores **O** Yes **O** No

Ringing in Ears **O** Yes **O** No Blood in Urine **O** Yes **O** No Lesion **O** Yes **O No**

Vertigo **O** Yes **O** No Hx of Kidney Stones **O** Yes **O** No Hives/Eczema **O** Yes **O** No

 Hx of STD’s **O** Yes **O** No

**Cardiovascular** **Psychiatric Neurological**

Chest Pain **O** Yes **O** No Anxiety/Depression **O** Yes **O** No Seizures **O** Yes **O** No

Dizziness **O** Yes **O** No Mood Swings **O** Yes **O** No Weakness/Paralysis **O** Yes **O** No

Fainting Spells **O** Yes **O** No Difficulty Sleeping **O** Yes **O** No Numbness **O** Yes  **O** No

Shortness of Breath **O** Yes **O** No Tremors **O** Yes **O** N**o**

Irregular Heartbeat **O** Yes **O** No Headaches **O** Yes **O** No

Difficulty Lying Flat **O** Yes **O** No **Endocrine** Migraines **O** Yes **O** No

High Blood Pressure **O** Yes **O** No Increased Thirst **O** Yes **O** No

Vascular Disease **O** Yes **O** No Increased Hunger **O** Yes **O** No **Immunological**

 Increased Urination **O** Yes **O** No Hives **O** Yes **O** No

 Increased Sweating **O** Yes **O** No Itching **O** Yes **O** No

**Constitutional** Fingernail Changes **O** Yes **O** No Runny Nose **O** Yes **O** No

Fatigue/Weakness **O** Yes **O** No Diabetes **O** Yes **O** No Sinus pressure **O** Yes **O** No

Fever **O** Yes **O** No

Weight Loss/Gain **O** Yes **O** No

**INSURANCE/BILLING AUTHORIZATION**

I request that payment of authorized Insurance Benefits for any services furnished me, be made on my behalf to *Optometric Associates of Warren County. P.C.*

I authorize any holder of medical information about me to release to my insurance company and it’s agents any information needed to determine those benefits payable for related services.

**I understand that I am responsible for all charges incurred not payable/covered by my insurance plan.**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**