# WELCOME TO OUR OFFICE

## Patient Information

**DATE** _____

Last _____
First _____ MI _____
Street _____
City _____
State _____ Zip Code _____
Home Phone _____
Cell Phone _____
Work Phone _____
Date of Birth _____ Age _____
Sex ☐ M ☐ F

Single ____ Married ____ Divorced ____ Widowed ____

Patient''s SSN XXX-XX- _____
Employer (Or School) _____
Spouse (Or Parent's Name) _____
Email _____
What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

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

☐ Blurry Vision
☐ Cataracts
☐ Crossed Eye/Eye Turn
☐ Eye Infections
☐ Flash of Light
☐ Glaucoma
☐ Headaches
☐ Itchiness
☐ Macular Degeneration
☐ Retinal Detachment
☐ Tearing
☐ Uncomfortable Glasses
☐ Other eye disorders or eye surgeries
☐ Burning
☐ Corneal Abrasions
☐ Double Vision
☐ Eye Injury
☐ Floaters/Spots
☐ Grittiness
☐ Iritis/Uveitis
☐ Lazy Eye
☐ Occasional Dryness
☐ Sunlight Sensetivity
☐ Tearing
☐ Trouble Seeing at Night

## Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN XXX-XX ___ ___ ___ ___
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber ID _____
Subscriber Birth Date _____

Do you participate in a flex spending account?
☐ Yes ☐ No

How will you settle your account today?
☐ Cash ☐ Check ☐ Credit Card

### Medicare Release

I authorize benefits to be paid directly to RW Optometric CenterInc/dba, Dr. Robert Wolf. I understand that I am financially responsible for services and materials that Medicare does not cover. I authorize Dr. Robert Wolf or my insurance company(s) to release any information to process my claims. I authorize the release of any medical information necessary to process my claims and the release of information to my referring or primary care physician. Your signature will serve as your "signature on file" for processing Medicare claims.

Signature _____

**HIPPA Privacy Practice acknowledgement:** I have received or was offered and declined a notice of privacy practices

Signature _____ Date _____

**What is your ethnicity?** Hispanic/Latino ____ Non Hispanic/Latino ____ Unknown/Not Reported ____

**What is your race?** Native Hawaiian ____ American Indian ____ African American ____ White ____ Unknown/Not Reported ____

**What is your preferred language?** English ____ Spanish ____ Other ____

**How did you hear about us?** Website ____ Friend ____

*PLEASE ANSWER QUESTIONS ON BACK OF FORM »*

**The information in this confidential case history form is critical to the evaluation of your vision and health.**

## Patient Medical History

Name of Family Physician _____
Town _____
Date of last physical check-up _____

**CURRENT MEDICATIONS (Rx or Over the Counter)**
(List name of medications including eye drops, vitamins, & birth control) **If you have a list, we'll copy it**

Height ____ Weight ____

| **Have you ever been diagnosed or treated for the following health problems?** | **Yes** | **No** |
|---|---|---|
| ☐ Allergies | ☐ | ☐ |
| ☐ Arthritis | ☐ | ☐ |
| ☐ Blood/Lymph | ☐ | ☐ |
| ☐ Bronchitis | ☐ | ☐ |
| ☐ Cancer | ☐ | ☐ |
| ☐ Cholesterol | ☐ | ☐ |
| ☐ Diabetes | ☐ | ☐ |
| ☐ Digestive | ☐ | ☐ |
| ☐ Ears/Nose/Throat | ☐ | ☐ |
| ☐ Endocrine | ☐ | ☐ |
| ☐ Eczema/Rashes | ☐ | ☐ |
| ☐ Fatigue | ☐ | ☐ |
| ☐ Fevers | ☐ | ☐ |
| ☐ Genitourinary | ☐ | ☐ |
| ☐ High Blood Pressure | ☐ | ☐ |
| ☐ Integumentary (Skin) | ☐ | ☐ |
| ☐ Kidney | ☐ | ☐ |
| ☐ Muscle/Bone | ☐ | ☐ |
| ☐ Neurological | ☐ | ☐ |
| ☐ Psychological | ☐ | ☐ |
| ☐ Respiratory | ☐ | ☐ |
| ☐ Sinus | ☐ | ☐ |
| ☐ Throat Infections | ☐ | ☐ |
| ☐ Thyriod | ☐ | ☐ |
| ☐ Unusual Weight Losses/Gains | ☐ | ☐ |
| ☐ Allergies to Medications? | ☐ | ☐ |

If so, what medications?

Reaction? _____
Date of First Reaction? _____

## Patient Eye History

Date of last eye exam? _____
By whom? _____

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No
What kind? _____
Solutions used _____

**If you are 13 years or older, what is your smoking history?**
Never ____ Former ____ Current ____ Some Days ____
Every Day ____

**Do you drink Alcohol? # of drinks a day ____ a week ____**

**Do you ever feel depressed?** _____

## Family Medical/Eye History (Check all that apply)

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

☐ Yes (Please Check Boxes) ☐ No

| | | Relationship (Mother's or Father's Side) |
|---|---|---|
| Blindness | ☐ | _____ |
| Cataracts | ☐ | _____ |
| Corneal Problems | ☐ | _____ |
| Diabetes | ☐ | _____ |
| Glaucoma | ☐ | _____ |
| Heart Disease | ☐ | _____ |
| Lazy Eye | ☐ | _____ |
| Macular Degeneration | ☐ | _____ |
| Retinal Problems | ☐ | _____ |

**Anything else we should know?**