WOLFEYECARE

Patient Information

DATE _____

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

Single ____ Married ____ Divorced ____ Widowed ____

Patient's SSN (Last 4 Digits ONLY) __ __ __ __
Employer (Or School) _____
Spouse (Or Parent's Name) _____

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
- ☐ Trouble Seeing at Night

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN (Last 4 Digits ONLY) __ __ __ __
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 THE 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*	*Explain*
Fever	☐	☐	_____
Fatigue	☐	☐	_____
Unusual Weight Losses/Gains	☐	☐	_____
Integumentary (Skin)	☐	☐	_____
Eczema/ Rashes	☐	☐	_____
Cancer	☐	☐	_____
Neurological	☐	☐	_____
Endocrine	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid	☐	☐	_____
Ear/Nose/Throat	☐	☐	_____
Allergies	☐	☐	_____
Sinus	☐	☐	_____
Throat Infections	☐	☐	_____
Respiratory	☐	☐	_____
Bronchitis	☐	☐	_____
Digestive	☐	☐	_____
Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Genitourinary	☐	☐	_____
Kidney	☐	☐	_____
Muscle/Bone	☐	☐	_____
Arthritis	☐	☐	_____
Blood/Lymph	☐	☐	_____
Psychological	☐	☐	_____
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?