WELCOME!

PATIENT INFORMATION

Patient's Last name: First: MI:

Social Security:

(ONLY if using INSURANCE)

E-mail:

Home Phone: Cell Phone: Other: Birthdate: / / Age:

Address:

City: State: ZIP Code:

Occupation, Hobby: Employer: Computer Use hours:

Chose office because/Referred to by (please check one box): ❑ Dr.(Primary) ❑ School ❑ Insurance Plan

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet/Website, Facebook ❑ Local Magazine ❑ WALK - IN

Other family members/friends seen here:

OCULAR & MEDICAL HISTORY

Last Eye Exam:

Reason for today's visit:
Exam____ Glasses____ Contact Lenses____ Medical Visit_____

Last Medical Exam:

Do you wear Contact Lenses?
❑ Yes / ❑ No

If so, what Brand:

Do YOU sleep with contacts? ❑ YES / ❑ No

DISPOSE CL'S? DAILY / 2 WEEKS
MONTHLY / RIGID /_____

What solution do you use to CLEAN Contacts?
OptiFree, BioTrue, Complete, Revitalens, Clear Care

Have YOU ever had any EYE INJURY, SURGERY OR INFECTION? _____

Are YOU interested in LASIK Surgery?

❑ YES / ❑ No

Do YOU have any of the following?

❑ High Blood Pressure ❑ Diabetes ❑ High Cholesterol

❑ Thyroid ❑ Heart Disease / Stroke ❑ Cancer ❑ Other

_____

❑ Depression / Anxiety
❑ Asthma
❑ Anemia/ Arthritis /Hearing Loss

Do YOU or any of your family members have?

❑ Glaucoma ❑ Retinal Disease ❑ Cataract ❑ Macular Degeneration:
(Self or Family) _____

❑ Amblyopia (Lazy Eye)
❑ Strabismus (Eye turn)
❑ Blindness

What are YOUR Visual /Ocular Complaints?

❑ Blur @ Distance / Near ❑ Loss of Vision ❑ Ocular Pain ❑ Burning ❑ Tearing ❑ Itching ❑ Redness ❑ Stye

❑ Floaters / Flashes ❑ Light Sensitivity ❑ Headaches / Migraines Other:

What MEDICATIONS do you take, if any?

Do YOU have any ALLERGIES?

(Women Only) Are you PREGNANT/NURSING? ❑ Yes / ❑ No

DILATION INFORMATION

To provide the most complete evaluation of your eyes, it is necessary to administer drops to dilate your pupils. The dilation will temporarily affect your vision for 3-4 hours. We will provide sunshades for driving for maximum comfort:

❑ YES, DILATE MY PUPILS TODAY ❑ RESCHEDULE DILATION FOR ANOTHER DAY ❑ NO, I REFUSE DILATION TODAY

INSURANCE INFORMATION

(PLEASE GIVE PHOTO ID & INSURANCE CARD TO RECEPTIONIST)

VISION INSURANCE: ID:

MAIN SUBSCRIBER NAME, DATE OF BIRTH:

MEDICAL INSURANCE: ID:

MAIN SUBSCRIBER NAME, DATE OF BIRTH:

I authorize my insurance benefit to be paid directly to My Eye Doctor Optical (Dr. Amarella Dalmazzo). **I understand that I am financially responsible for any balance that is not covered by my insurance**. An Authorization does not guarantee payment.

I also authorize My Eye Doctor Optical, or my insurance company to release any information required to process my claims. We have "Notice of Privacy Practices" that describes the use and disclosure of your personal medical information in detail as per federal law. (copies at front desk)

PATIENT /GUARDIAN SIGNATURE: _____ DATE:_____