Ins.: Ins. ID:

NAME (first)________________ (last)________________

TODAY'S DATE ______ / ______ / ______ YOUR DATE OF BIRTH ______ / ______ / ______

E-MAIL: ____________ @ ____________ OCCUPATION ________________

PHONE (home or cell) ________________ (Work) ________________

ADDRESS: Street ________________ (PO Box, apt)________________

City ________________ State ______ Zip________

(NEW PATIENTS ONLY) How did you learn about us?________________

PLEASE LIST ANY MEDICATIONS TAKEN AND THE CONDITION(S) BEING TREATED:

____

ANY FAMILY HISTORY OF EYE CONDITIONS? (If so, please list condition and to whom it refers):

____

CONCERNS TO BE ADDRESSED DURING THIS EXAMINATION (check which apply) :

[ ] None; routine examination
[ ] Blurred vision up close
[ ] Difficulty refocusing when looking away from the computer
[ ] General eyestrain
[ ] Contact lens evaluation (new wearer)
[ ] Contact lens update (previous wearer)
[ ] Obstructions in or missing parts of field of vision
[ ] Blurred vision at distance
[ ] Headaches possibly related to eye use
[ ] Double vision
[ ] Refractive surgery evaluation
[ ] Visual disturbances - light flashes, floaters
[ ] Dry eye or eye allergy discomfort
[ ] Treatment for eye irritation, infection or injury

OTHER CONCERNS OR COMMENTS:________________

____

ANY ABNORMALITIES REPORTED FROM PRIOR EYE EXAM(S) ________________

____

__DO YOU WISH TO HAVE RETINAL PHOTOGRAPHS INCLUDED IN YOUR EXAMINATION?__ High-resolution photographs of the backs of your eyes can reveal changes in eye health which may not otherwise be apparent. If you or your family have diabetes, hypertension, macular degeneration or glaucoma or if you are over 40, photographs are recommended. A $25 fee will apply unless photographs are covered by health insurance when following certain medical conditions.

______ Yes, please include retinal photographs in my examination ______ No thank you, perhaps at a future appointment

__PLEASE COMPLETE THE FOLLOWING:__ I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION ACCORDING TO HIPAA REGULATIONS AND, WHEN APPROPRIATE, AUTHORIZE PENNSYLVANIA OPTOMETRICS TO BILL MY INSURANCE COMPANY FOR COVERED SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ANY CLAIM WHICH MAY BE DENIED.

Date: ______ / ______ / ______ Patient (if other, relationship to patient)________________