Welcome to Family Tree Optometric!

Patient Information **New Pts**

Last: First: Middle Initial: Title: Gender:

Address: City: State: Zip:

Mobile#: Home#: Work#: SS#: DOB:

Preferred method of contact: ☐ Text / ☐ Mobile / ☐ Home / ☐ Email

Email: We respect your privacy, we only use emails to remind you of appointments.

Emergency Contact: Phone#: Relationship to patient:

Occupation:

How did you hear about us?: Referred by:

Primary Care Physician: Last Medical Exam:

If Completing for Your Child:

Guardian: Relation to patient: Phone:

Insurance Information **New Pts**

Primary Insured Person's Information:

Last: First: SS#: DOB:

Insurance Provider: ☐ VSP ☐ MES ☐ MediCare

Eye Conditions/ Symptoms **Check all that apply** **All**

☐ Blurred vision	☐ Double Vision	☐ Itching	☐ Dryness	☐ Discharge
☐ Cataracts	☐ Glaucoma	☐ Burning	☐ Redness	☐ Tired Eyes
☐ Excess Tearing	☐ Eye/ Lid Infection	☐ Flashes/ Floaters	☐ Sandy/ Grittiness	☐ Light Sensitivity
☐ Loss of Side Vision	☐ Distorted Vision/ Halos	☐ Styes	☐ Retinal Detachment/ Disease	

Personal and Family Eye/ Medical History **Check all that apply** **All**

☐ **NONE**

	Me	Mother	Father	Sibling	Grandparent
Amblyopia/ Lazy Eye _____	☐	☐	☐	☐	☐
Blindness _____	☐	☐	☐	☐	☐
Cataracts _____	☐	☐	☐	☐	☐
Corneal Transplant _____	☐	☐	☐	☐	☐
Glaucoma _____	☐	☐	☐	☐	☐
Macular Degeneration _____	☐	☐	☐	☐	☐
Retinal Detachment _____	☐	☐	☐	☐	☐
Strabismus/ Eye Turn _____	☐	☐	☐	☐	☐
Arthritis _____	☐	☐	☐	☐	☐
Asthma _____	☐	☐	☐	☐	☐
Cancer _____	☐	☐	☐	☐	☐
Diabetes A1C_____% Blood Sugar_____.	☐	☐	☐	☐	☐
Heart Disease _____	☐	☐	☐	☐	☐
High Cholesterol _____	☐	☐	☐	☐	☐
High Blood Pressure _____	☐	☐	☐	☐	☐
Seizures _____	☐	☐	☐	☐	☐
Stroke _____	☐	☐	☐	☐	☐
Thyroid _____	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

Describe any previous surgeries, eye or medical:

Medications and Allergies

All

List any current medications/ supplements
☐ None

1 _____ for _____
2 _____ for _____
3 _____ for _____
4 _____ for _____
5 _____ for _____
6 _____ for _____
7 _____ for _____
8 _____ for _____
9 _____ for _____
10 _____ for _____

List any allergies drug or environmental
☐ None

1 _____ Reaction _____
2 _____ Reaction _____
3 _____ Reaction _____
4 _____ Reaction _____
5 _____ Reaction _____
6 _____ Reaction _____
7 _____ Reaction _____
8 _____ Reaction _____
9 _____ Reaction _____
10 _____ Reaction _____

Social History *Please check all that apply

All

☐ Tobacco Use ☐ Recreational Drugs ☐ Blood Transfusion

☐ Alcohol Consumption ☐ Sexually Transmitted Disease Exposure?

*This information is strictly confidential, if you prefer you can discuss this with your doctor in private.

Personal Eye History

New Pts

Last Eye Exam: Last Dilation: □Eye medications / □Eye Drops
Please List:

Do you wear glasses? ☐ Yes / ☐ No ☐ Full time / ☐ Part time How old is your current pair? _____

Type of Glasses: ☐ Readers / ☐ Distance / ☐ Progressive / ☐ Bifocal / ☐ Computer / ☐ Safety / ☐ Other

Do you wear contacts? Full time/ partime How old is your current pair? _____

Type of contact lenses: ☐ Soft/ ☐ Rigid/ ☐ Gas Permeable/ ☐ Daily/ ☐ Other

Are they Comfortable? ☐ Yes / ☐ No

Review of Systems Check All that apply All

	Yes	No	Not Sure
Allergies:	☐	☐	☐
Cardiovascular:			
High Cholesterol	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Constitutional:			
Fever	☐	☐	☐
Weight Loss	☐	☐	☐
Endocrine/Glands:			
Diabetes	☐	☐	☐
Thyroid/ Other Glands	☐	☐	☐
Gastrointestinal:			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary:			
Genitals/ Kidney/ Bladder	☐	☐	☐
Ears/Nose/Mouth/Throat (Head):			
Allergies/ Hay fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Post-nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/ Mouth	☐	☐	☐

	Yes	No	Not Sure
Hematologic/ Lymphatic :			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Immunologic:			
Viral or bacterial infection	☐	☐	☐
Intergumentary (Skin):	☐	☐	☐
Skin Problems	☐	☐	☐
Bones/Joints/Muscles (Musculoskeletal):			
Rheumatoid Arthritis	☐	☐	☐
Muscles Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Neurological:			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Psychiatric:			
Eg: Depression/ Bi-polar	☐	☐	☐
Respiratory:			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐

Weight: _____ Height: _____

REQUIRED Financial Policy Acknowledgement

All

I understand that I am financially responsible for charges when services are rendered. If my insurance is billed I am responsible for services, material, or deductibles not covered, and authorize Family Tree Optometric to release medical information necessary to my insurance company to process claims submitted on my behalf.

Signature: _____ Date: _____

REQUIRED- HIPAA: Acknowledgement of "Notice of Privacy Practices"

All

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, examination, test results, diagnoses, treatment and any plans for future care.

The "Notice of Privacy Practices" which describes these uses and disclosured in detail is posted to view in our office. A copy can also be provided upon request. HIPAA has been updated as of February 2, 2015

Signing this statement signifies you have received a copy or have chosen to read our "Notice of Privacy Practices"

Print name of responsible party: Signature: Date :

REQUIRED- Authorization to Release Medical Information

All

I authorize Family Tree Optometric to release my medical records to the following. All medical sources, including any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

Patient/ Guardian's Name: DOB: Date:

Signature: Date:

Authorization to Release Medical Information to Individual

All

☐ I **agree** to release my healthcare information to the person listed below. They may receive any information related to my healthcare, prescriptions, diagnoses, treatment, procedures, schedules, completed chart, discharge summaries, consultations, lab work, schedules or any other care I receive. This authorization, as may be applicable, extends to any medical records covered by any privilege, including without limitation to psychiatric, psychological and mental testing and records; records relating to drug treatment and/or substance abuse; records related to sexually transmitted diseases and/or social service notes.

Name : Relation to Patient: Contact number:

Address: City: State: Zip:

☐ I **do not agree** to release my healthcare information with anyone except as it relates to the "Notice of Privacy Practices" agreed to above.

Signature: Date: