REGISTRATION & HISTORY **SOLDOTNA OPTOMETRY CLINIC, LLC**

Name______________________Nickname__________Gender M F Date of Birth____________

Mailing Address______________________City________________State_______Zip______

SSN# (Patient)______________________SSN# (Responsible Party)______________________

Phone # (Hm)____________(Wk)___________(Cell)___________(email)_____________

Occupation__________________________or School________________Grade________

Employer_____________________________

Race/Ethnicity______________________Preferred Language_________________________

Spouse/Parent______________________Name of Responsible Party____________________

Emergency Contact/Telephone #__________________Referred by_______________________

______________________________ ______________________________

Signature of Patient/Responsible Party **Date**

INSURANCE COVERAGE INFORMATION:

Primary Insurer:
Insurance Company Name________________
Subscriber Name______________________
Subscriber Date of Birth________________
Subscriber ID #______________________
Group #___________________________

Secondary Insurer:
Insurance Company Name________________
Subscriber Name______________________
Subscriber Date of Birth________________
Subscriber ID #______________________
Group #___________________________

We bill insurance as a courtesy service to our patients. Payment is expected for the portion of the charges that your insurance will not cover on the date of service.

If you would like us to bill your insurance company, you can assign the benefits to our office by signing the correct section of your insurance form, or you can fill out the Assignment and Release section below. If there is a balance owing after the insurance benefits are paid, we will send you a statement for payment.

ASSIGNMENT AND RELEASE:

I, the undersigned, assign directly to Dr. John Demske all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________ ______________________________

Signature of Insured/Guardian **Date**

I acknowledge that I received a copy of the "Notice of Privacy Practices - February 11, 2013" for Soldotna Optometry Clinic, LLC

______________________________ ______________________________

Signature of Patient/Guardian **Date**

MEDICAL INFORMATION:

Why are you here today?____

Please **circle** any of these symptoms/problems that you experience: Blurring up close, Blurring at distance, peripheral vision, night vision, color vision, dryness, itching, burning, tearing, soreness, aching, pain, light sensitivity, discharge, tired eyes, flashes, floaters

How long has it been like this?____

Have you used any medicine for your eye?__________________________ Fish Oil? **Y/N** EyeDrops or Artificial Tears **Y/N**

If injury, did it occur on the job? **Y/N** Were you wearing eye protection? **Y/N** Did your eye protection have sideshields? **Y/N**

If work related, do you have Workman's Comp. Insurance? **Y/N**

Computer Use? **Y/N** Hrs. per day_______________________

Feeling OK? **Y/N** Headache? **Y/N** Where?________How Often?_______Migraines?_______Weight Loss/Gain?_________

Date of last eye examination?___________Were your pupils dilated? **Y/N** Date of last physical examination?_________________

Family Doctor?____________________________Do you drive? **Y/N** Problems Driving?______________________________

Do you wear glasses? **Y/N** Contact Lenses? **Y/N** Type? (please **circle** **one**) RGP; Soft, Soft Toric for astigmatism, Dailies, Hybrid

Women only: Are you pregnant?_____________________Nursing?______________Are you using oral contraceptives? **Y/N**

Children only: Normal development?_____________________Was pregnancy normal term?____________________________

REVIEW OF SYMPTOMS (please circle all that apply)

Constitution: Fatigue Syndrome, Cancer, Developmental Disabilities, Other____

ENT: Hearing Loss, Dry Mouth, Sinusitis, Laryngitis, Other____

Neurological: Migraine, Stroke/CVA, Tumor, Epilepsy, Cerebral Palsy, Multiple Sclerosis, Other_________________________

Psychiatric: Bipolar Disorder, Anxiety Disorder, Depression, Attention Deficit, Other___________________________________

Cardiovascular: Heart Disease, Hypertension, Congestive Heart Failure, Vascular Disease, Heart attack/MI, Stents
Other____

Respiratory: Asthma, Cigarette Smoker, Bronchitis, Chronic Obstruction, Emphysema, Other____________________________

Gastrointestinal: Acid Reflux, Celiac Disease, Colitis, Crohn's, Ulcer, Other____

Genitourinary: Prostate disease/cancer, Chlamydia, Kidney Disease, Nursing, Herpes, Pregnant, STD, Other_________________

Musculoskeletal: Osteoarthritis, Muscular Dystrophy, Arthritis, Gout, Ankylosing Spondylitis, Osteoporosis, Fibromyalgia
Other____

Integumentary: Psoriasis, Eczema, Rosacea, Herpes Zoster/Shingles, Herpes Simplex/Cold sores, Other______________________

Endocrine: Type 1 Diabetes Mellitus, Type 2 Diabetes Mellitus, Thyroid dysfunction, Hormonal dysfunction, Other_____________

Hematologic/Lymphatic: Hypercholesterolemia, Ulcer, Anemia, Large volume blood loss, Other_____________________________

Allergic/Immune: Environmental Allergies, Drug Allergies, Rheumatoid Arthritis, Lupus, Sjogren's Syndrome, Latex Sensitivity

Please list **all** allergies:____

PERSONAL HISTORY (please circle all that apply)

Ocular: Surgery, Strabismus, Age-related Macular Degeneration, Retinal Detachment, Retinal Hole, Retinal Degeneration, Glaucoma, Glaucoma Suspect, Inflammatory Disorder, Keratoconus, Injury, Cataract, Amblyopia, Patching

Other____

Hobbies____

Have you had any eye operations? **Y/N** Type of operation____

Have you had any eye injuries? **Y/N** Type of injury____

Have you had any recent surgeries? **Y/N** Type of surgery____

Do you use tobacco products? **Y/N** packs per day?_______Smokeless Tobacco? **Y/N**
Are you a former smoker? **Y/N**
Alcohol? **Y/N** How often?______________
Substance abuse? (other than tobacco or alcohol) **Y/N**

FAMILY HISTORY (please circle all that apply)

Medical

Diabetes:	(list family relationship)__________________________
Thyroid:	(list family relationship)__________________________
Hypertension:	(list family relationship)__________________________
Cancer:	(list family relationship)__________________________
Other:	(list family relationship)__________________________

Ocular

Severe Hyperopia:	(list family relationship)__________________________
Severe Myopia:	(list family relationship)__________________________
Glaucoma:	(list family relationship)__________________________
Glaucoma Suspect:	(list family relationship)__________________________
Macular Degeneration:	(list family relationship)__________________________
Strabismus:	(list family relationship)__________________________
Amblyopia:	(list family relationship)__________________________
Cataract:	(list family relationship)__________________________
Retinal Detachment:	(list family relationship)__________________________
Other:	(list family relationship)__________________________

Are you taking any medication now? Prescription:____

____

Over the counter:___________________________Alternative, Homeopathic, Herbal:_____________________