REGISTRATION & HISTORY **SOLDOTNA OPTOMETRY CLINIC**

Name_____Nickname_____Gender M F Dateof 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. David Holdgrafer 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 Patient/Responsible Party **Date**

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

_____ _____
Signature of Patient/Responsible Party **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, Autism Spectrum Disorder,

Other_____

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

Cardiovascular: Heart Disease, Hypertension, Congestive Heart Failure, Heart Attack, Vascular Disease, Stents,

Other_____

Respiratory: Asthma, Cigarette Smoker, Bronchitis, Chronic Obstruction, Emphysema, Sleep Apnea, 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_____

DIABETICS: Last Hba1c_____ on date_____ Last Sugar Level_____ on date_____

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** **List**_____

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:_____