Welcome to Optical Concepts!

Name ____ **Preferred Name** ___________________ ☐**Male** ☐**Female**
Date of Birth ________/_______/___________ **Social Security #** ___________-_________-__________
Address: Street ____
City____________________________ **State**________ **Zip**__________
Phone: Home _______________________ **Cell** _______________________ **Work** ______________________

Email____

How did you hear about our office? ☐Internet ☐Professional; *Dr.*_______________ ☐Patient Referral ________________

Ethnicity
☐Decline to specify
☐Hispanic/Latino
☐Not Hispanic/Latino

Preferred Language
☐Decline to specify
☐English
☐Spanish
☐Other ___________

Race
☐Decline to specify
☐Alaska Native
☐Asian
☐Black/African-American
☐Hispanic
☐Native Hawaiian or Other Pacific Islander
☐White

Occupation__________________________
Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Employment Status ☐Employed Full-Time ☐Employed Part-Time ☐Retired ☐Full-Time Student

---

- **Primary Medical Insurance:** _________________________ **ID#** _________________________

Policyholder's Name: ______________________ Social Security # _____-_____-_____ DOB____/___/_____

- **Vision Plan/Union:** ______________________________ **ID#** _________________________

Policyholder's Name: ______________________ Social Security # _____-_____-_____ DOB____/___/_____

PHARMACY :
Name ____________________________________
Phone Number ____________________________
Town____________________________________

PRIMARY CARE PHYSICIAN:
Date of last physical exam: _____/_____/_____
Dr . _____________________________
Phone Number ___________________Fax __________________

MEDICATION/ VITAMIN/ SUPPLEMENT LIST:

_________________________________ _________________________________ _________________________________

_________________________________ _________________________________ _________________________________

Emergency Contact Name ______________________________ Phone Number_________________________

Do you currently wear glasses? ☐None ☐Distance ☐Reading ☐Bifocal ☐Progressive ☐Prescription Sunglasses
Are you interested in contact lenses? ☐Yes ☐No

If you are already wearing contact lenses: What Brand do you wear? ________________________
Any contact lens discomfort? ☐Yes ☐No **Disposal**: ☐Daily ☐Bi-Weekly ☐Monthly ☐Other_________________________

What solution/cleaner do you use?__________________________________
How often are they worn? _____ Days/Week _____ Hours/Day

	Prescription	BC/DIA
Right		
Left		

Are you Currently experiencing any of the following:

Yes	No		Yes	No	
☐	☐	Blurry vision when using a computer	☐	☐	Burning/pain
☐	☐	Blurry vision when reading	☐	☐	Itching
☐	☐	Blurred distance vision	☐	☐	Excessive tearing/watery eyes
☐	☐	Difficulty seeing at night	☐	☐	Tired eyes
☐	☐	Problems with nighttime driving	☐	☐	Contact lens discomfort
☐	☐	Glare	☐	☐	Sandy or gritty feeling in the eyes
☐	☐	Flashing lights	☐	☐	Discharge
☐	☐	Floaters	☐	☐	Redness
☐	☐	Double vision	☐	☐	Light Sensitivity
☐	☐	Headaches			

Have you had any ocular surgeries? Explain ________________________________ When ______________________________________

Have you ever injured your eyes? How __________________________________ When ______________________________________

Do you use any eye drops? No___Yes___Name ______________________ How Often __________________________________

MEDICAL HISTORY:

Do you drink alcohol? ☐No ☐Yes, how often ____________

Do you smoke? ☐No ☐Yes, how often ____________ If quit, how long ago______________________

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Allergic/Immunologic
- ☐ Drug allergy___________
- ☐ Environmental allergy
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Other______________

Cardiovascular
- ☐ Heart disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular disease
- ☐ High cholesterol
- ☐ Other______________

Constitutional
- ☐ Developmental disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other______________

Endocrine
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Thyroid dysfunction
- ☐ Hormonal dysfunction
- ☐ Other______________

Gastrointestinal
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Acid reflux
- ☐ Other______________

Genitourinary
- ☐ STD
- ☐ Bladder
- ☐ Prostate
- ☐ Other______________

Ear, Nose, Mouth, Throat
- ☐ Inner ear
- ☐ Sinus
- ☐ Hearing loss
- ☐ Other______________

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Leukemia
- ☐ Other______________

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Other______________

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other______________

Neurological
- ☐ Cerebral palsy
- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Epilepsy
- ☐ Other______________

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Panic disorder
- ☐ Schizophrenia
- ☐ ADD/ADHD
- ☐ Other______________

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Other_____________

List any hospitalizations, surgeries or additional detail:

____

FAMILY HISTORY *(Parents, Siblings or Children)*

Medical Condition		Relationship	
High Blood Pressure	Y	N	________________
Diabetes	Y	N	________________
Heart Disease	Y	N	________________
Cancer	Y	N	________________
Stroke	Y	N	________________
High Cholesterol	Y	N	________________
Kidney Disease	Y	N	________________

Ocular Condition			Relationship
Glaucoma	Y	N	________________
Cataracts	Y	N	________________
Macular Degeneration	Y	N	________________
Blindness	Y	N	________________
Retinal Detachment	Y	N	________________
Other Conditions	Y	N	________________

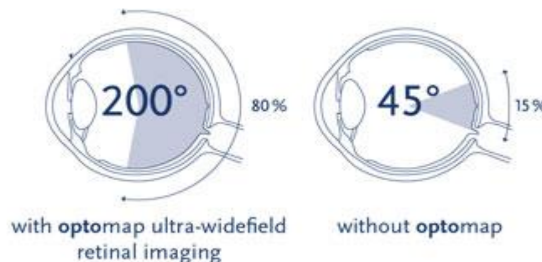
I certify that information pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Optical Concepts. I authorize release of medical information necessary to process this (these) claim(s). I have read all terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature: ____ Date: _______________________

We recommend including Optomap Imaging as part of Your Comprehensive Eye Exam.

Benefits of the Optomap:

- **Early detection of sight-threatening conditions such as glaucoma, macular degeneration and retinal holes or tears.**
- **Early detection of diseases like Cancer, Stroke and Cardiovascular disease.**
- **Immediately review results with us in the Exam Room.**
- **Can be done instead of dilating your eyes.**
- **Is as fast as taking a picture.**
- **DOES NOT REQUIRE DILATING DROPS.**



Your insurance/vision plan is designed to allow a basic eye exam and may not cover advanced screening tools such as the Optomap. We believe this state of the art technology is in our patient's best medical interest.
The Optomap screening is only $45.

- *_____ *Yes, I am interested in using the Optomap Technology*
- *_____ *I would like more information about Optomap*

*~Optical Concepts * Your Neighborhood Eye Care Professionals~*