PLEASE SIGN IN

NAME _____, _____ **DATE:** ____/____/20___

(LAST) **(FIRST)**

(PATIENT/GUARDIAN, if under 18 _____, _____ **RELATION TO PATIENT** _____**)**

ADDRESS _____ **APT** _____ **CITY** _____ **ST** _____ **ZIP** _____

PHONE # (_____) _____ **-** _____ **DATE OF BIRTH** ____ /____ / ____ **OCCUPATION**_____

EMAIL _____ (Your email address will ONLY be used for correspondences from *our office*)

How did you hear about us? ☐ Friend/Relative ☐ Another Patient ☐ Another Physician ☐ Our Sign ☐ Internet

☐ Other: _____ Whom may we thank for referring you to us? _____

When was your last eye exam**?** _____ Last ***dilated*** eye exam**?** _____ Last medical exam? _____

Reason for today's exam_____

Is today's examination for Contact Lenses? ☐ Yes ☐ No ☐ Not Sure **Are you pregnant or nursing?** ☐ Yes ☐ No

Do you experience / have you ever had any of the following:

___ severe eye pain	___ itching	___ redness	___ dryness	___ tearing/discharge
___ swelling	___ glare	___ "flashes" of light	___ "floaters" or spots	___ overly light sensitive
___eye injury	___ eye surgery	___ eye infection/disease	___ eye strain (currently)	___ medical eye treatment

___other_____

Do you ("**ME**") or anyone in your family ("**F**") have any of the following?

___ glaucoma	___ cataracts	___ lyme disease (you)	___ high cholesterol	___ diabetes
___ overly light sensitive	___ "lazy" eye	___ "hay fever"	___ hypertension	___ arthritis
___macular degeneration	___ turned eye	___ thyroid disorder	___ cancer/malignancy	___ HIV/AIDS/other VD
___ detached retina	___ blindness	___ kidney disorder	___ surgery (you)	___ headaches/migraines

___other_____

Please list **any** allergies you have (☐ none) _____

Please list **all** medications you are currently taking; including over-the-counter, oral contraceptives, aspirins, vitamins, supplements, home remedies (☐ none) _____

Please list **all** eye drops you are currently taking (☐ none) _____

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of this Notice of Privacy Practices.

_____

Patient Name or Legal Guardian (print)

_____

Signature