Blumenstock Family Eyecare

(Office Use Only)

CL New	I/R	Optos W	Refer
CL Established	IF/U	Optos M	Order Trials

Last Name:________________ First Name:________________ M____ DOB:___/___/___

M or F SSN:________________ Marital Status: Married / Single / Divorced / Widowed

Address:________________ City:________________ State:________ Zip:________

Home Ph: (____)____________ Work Ph: (____)____________ Cell Ph: (____)____________

Email Address:________________ Sports/Hobbies:________________

Preferred Method of contact: ☐ Email (above) ☐ Phone ________________ ☐Text (phone) ________________

Employer/School:________________ Occupation/School Grade:________________

Emergency Contact:________________ Relation:________________ Phone #:________________

Insurance Information (Please give your insurance card to front desk)

Name of Insurance Company________________ Primary Insured's Name ________________

Identification Number ________________ Group Number ________________ DOB: ___/___/___

Date of Last Medical Exam:___/___/___ **Primary Physician/Clinic:**________________

Date of Last Eye Exam: ___/___/___ **Clinic/Eye Doctor:** ________________

Review of Systems

Visual	No	Yes
Blurred Vision	☐	☐
Loss of Vision	☐	☐
Double Vision	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Dryness	☐	☐
Irritation	☐	☐
Redness	☐	☐
Itching/Burning	☐	☐
Discharge	☐	☐
Eye Pain/Soreness	☐	☐
Headaches	☐	☐
Poor Color Vision	☐	☐
Light Sensitive	☐	☐
Tired Eyes	☐	☐
Sandy/Gritty Feeling	☐	☐
Halos/Glare	☐	☐
Eye Infections	☐	☐
Eye Strain	☐	☐
History of Eye Trauma	☐	☐
Injury or Eye Surgery	☐	☐

Other________________

Medical History	No	Yes
High Blood Pressure	☐	☐
Stroke	☐	☐
Heart Disease	☐	☐
High Cholesterol	☐	☐
Diabetes	☐	☐
Thyroid Problem	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Cancer	☐	☐
ADHD	☐	☐
Depression	☐	☐
Schizophrenia	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Osteoarthritis/RA	☐	☐
Fibromyalgia	☐	☐
AIDS/HIV	☐	☐
Lupus	☐	☐
Hearing Loss	☐	☐
Eczema	☐	☐

Other________________

Family History	None	Self	Relative
Blindness	☐	☐	☐
Retinal Detachment	☐	☐	☐
Glaucoma	☐	☐	☐
Crossed Eyes	☐	☐	☐
Macular Degeneration	☐	☐	☐
Diabetes	☐	☐	☐
Cancer	☐	☐	☐
Heart Disease	☐	☐	☐
Cataracts	☐	☐	☐

Other________________

Are you currently pregnant or nursing? Y/ N

Alcohol Use: Y N Amount:________

Tobacco Use: Y N Amount:________

Medications: ☐ See attached medication list

- ________ For ________
- ________ For ________
- ________ For ________
- ________ For ________
- ________ For ________

Allergies (to medications and/or seasonal)

____

Insurance Authorization/HIPAA Notice

☐ I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for services.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.
☐ I acknowledge that I had the opportunity to review and have received a copy if so desired of Optical Gallery's Notice of Privacy Practices.

Signature:________________ **Date:**________________

Reviewed By: Dr. ________________ **Date:**________________