*Today's Date*___________________

Patient's Last Name ______________________ First Name ___________________ Preferred ________________

Address ____________________________________ City, St, Zip____

Telephone (H) _________________________ (C) ___________________________ Text? Yes or No

Email ____ ☐Male ☐ Female Pronouns __________

Date of Birth ___________________________ Marital Status: ☐S ☐ M ☐ W ☐ D

Occupation _______________________________ Employer ____

Emergency Contact/Telephone Number ____

If Child (Guardian Name): ____ Date of Birth___________________

Last Eye Exam:________________________________ How did you hear about us?_______________________

What are you thankful for?____

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Insurance Changes

If there are any changes to your insurance information, please notify our office immediately. Reagin Optometric Group will not be responsible for timely filing if we do not receive the correct insurance information prior to or at the time of the visit.

Returned Checks

All checks returned for insufficient funds, closed accounts or for any other reason will be subject to a $25.00 service charge. All further payments must be made either by credit card, money order or cash.

Deductibles/Coinsurance/Co-payments

Deductibles, coinsurance and co-payments will be collected at the time services are rendered. These are required by your insurance company and agreed upon by you when you accept their insurance. We also must contract with insurance companies, agreeing to collect co-payments, coinsurance and deductibles, in order to participate with their plans.

Acknowledgment of Notice of Privacy Practices (NPP)

- Yes, I have read or heard the NPP and wish to continue my care under said terms.
- No, I have not read this office's NPP, but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
- The NPP could not be read due to the emergent nature of the care needed.

Signature Acknowledgement: ___________________________________

What brings you in today? ______________________ Any: Burning Itching Redness Dryness Floaters Flashes

Do you wear glasses? Y N Do you wear contacts? Y N What type contact lenses? _______________

Have you had refractive surgery? (Lasik, PRK, RK) Y N Are you interested in refractive surgery? Y N

Please complete both sides of this form

Primary Care Physician: ____ Phone: ____________________________

Have you been diagnosed with or treated for any of the following?:

Yes/ No

☐ ☐ Cataracts

Cataract Surgery Date: Right Eye _______ Left Eye _______

☐ ☐ Corneal Disease: ______________________________

☐ ☐ Iritis

☐ ☐ Glaucoma

☐ ☐ Retinal Disease _____________________________

☐ ☐ Macular Degeneration Type? _________________

☐ ☐ Eye Injury Type:_____________________________

☐ ☐ Other Eye Disorders:__________________________

Other Eye Surgery: ____ Year ____________________

Have any immediate family members (grandparents, parents, siblings) been treated for the following?: If yes, who?

Yes/ No

☐ ☐ Glaucoma ______

☐ ☐ Cataracts ______

☐ ☐ Macular Degeneration ______

☐ ☐ Diabetic Retinopathy ______

☐ ☐ Diabetes ______

☐ ☐ Retinal Detachment ______

☐ ☐ Corneal Disease ______

☐ ☐ Retinitis Pigmentosa ______

☐ ☐ Other Significant Eye Problems ______

PERSONAL HEALTH HISTORY

Yes/ No

☐ ☐ Lung Disease – Type ___________________________

☐ ☐ Kidney Disease:_______________________________

☐ ☐ Arthritis:_____________________________________

☐ ☐ Neurological Disease:__________________________

☐ ☐ (Women) Are you Pregnant or nursing? ___________

☐ ☐ Stroke:_______________________________________

☐ ☐ HIV/AIDS:_________ Year Diagnosed?:__________

☐ ☐ Heart Disease:_________________________________

☐ ☐ Gastrointestinal Disease:________________________

☐ ☐ Do you smoke? Packs per Day:_________

☐ ☐ Do you drink? Drinks per Day:_________

☐ ☐ Head or Spinal Injuries: _________________________

☐ ☐ Seizures, Convulsions, Fainting:_________________

☐ ☐ Diabetes: Type 1 or Type 2 Year Diagnosed?: ____
If yes: Last Blood Sugar______ A1C____

☐ ☐ Endocrine Problems? _________________________

☐ ☐ Migraines:____________________________________

☐ ☐ Psychiatric Disorder:__________________________

☐ ☐ Herpes Simplex or Zoster (Shingles) _____________

☐ ☐ Cancer? Type_________ Year Diagnosed?:_______

☐ ☐ High Blood Pressure Year Diagnosed?:________

☐ ☐ High Cholesterol Year Diagnosed? ________

☐ ☐ Sleep Apnea Do you use a Cpap?______

Please list all medications (including eye medications) you are currently using: ____

____

Are you allergic to latex? ___________ Any medication allergies? ________________________

If yes, please list all medication
allergies:____