Welcome To Our Office

Please print or use block letters

Patient Information

Last Name: ______________________ **First Name**: ___________________ Middle Initial: _____ Preferred Name: ____________

Home Address: ____ City: _________________ State: _________ Zip: _________

Home Phone: (______) ________________ Cell Phone: (______) ________________ Work Phone: (______) ________________

Sex: M / F Birth Date: _____ / _____ / _____ Age: ______ SSN: __________________ Email: __________________________

Current Marital Status (check one)**:** ❑ Single ❑ Married ❑ Separated ❑ Divorced

Employer / School: ____________________________________ Occupation: _____________________ If student, grade: ______

Emergency Contact: ________________________________ Relationship: ______________ Phone: (______) ________________

How did you hear about us? ____

Insurance Information

Primary **Medical Insurance**: _____________________________ Policy Holder's Name: _________________________________

Vision Insurance: ______________________________________ Policy Holder's Social Security Number: __________________

Policy Holder's Employer: _________________________________ Policy Holder's Birth Date: _____ / _____ / _____

Do you participate in a Flex Spending Account? Yes / No If yes, you may use it for your visit, eyewear, and contact lens purchases.

Family Medical History

Has anyone in your family (that is, parents, siblings, children, or grandparents) been diagnosed with any of the following?
(check all that apply): ❑ No Problems ❑ Diabetes ❑ High blood pressure ❑ Cancer ❑ Blindness ❑ Other _____________

Has anyone in your family been diagnosed with any of the following eye problems? (check all that apply):
❑ No Problems ❑ Glaucoma ❑ Amblyopia (lazy eye) ❑ Cataracts ❑ Macular degeneration ❑ Strabismus (eye turn)

Medical History

Medications (prescriptions & over-the-counter): ____

____

Allergies (medicines, pollen, chemicals, hay fever, etc.): ____

____

Primary Care Physician / Practice: ____ City: ________________________

What is the reason for your visit? ____

(Please continue on the other side)

Do you or have you experienced any of the following? (check all that apply):

- ❑ Itchy eyes ❑ Tearing eyes ❑ Burning eyes ❑ Flashes or spots ❑ Blurred vision ❑ Eye pain ❑ Sandy/Gritty feeling
- ❑ Glare ❑ Dry eyes ❑ Red eyes ❑ Light sensitivity ❑ Lost vision ❑ Other ______________________

- Women: Are you pregnant? (circle one): Yes No If yes, how long? ______________________
- Do you smoke? Yes No If yes, how much? ______________________
- Do you consume alcohol? Yes No If yes, how much? ______________________

Have you been diagnosed with or treated for any of the following problems? (check all that apply):

Ocular/Eye
- ❑ Inflammatory Disorder
- ❑ Surgery
- ❑ Glaucoma
- ❑ Amblyopia (lazy eye)
- ❑ Cataract
- ❑ Retinal Problems
- ❑ Macular degeneration
- ❑ Strabismus (eye turn)
- ❑ Patching

Constitutional
- ❑ Cancer
- ❑ Fatigue
- ❑ Developmental Disability

Ear, Nose, Mouth, Throat
- ❑ Laryngitis
- ❑ Dry Mouth
- ❑ Hearing Loss
- ❑ Sinusitis

Neurological
- ❑ Cerebral Palsy
- ❑ Multiple Sclerosis
- ❑ Tumor
- ❑ Epilepsy
- ❑ Seizures
- ❑ Headaches / Migraines

Cardiovascular
- ❑ Vascular Disease
- ❑ Stroke
- ❑ Congestive Heart Failure
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol

Skin
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Eczema

Respiratory
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Smoker
- ❑ COPD
- ❑ Asthma

Gastrointestinal
- ❑ Prostate Disease/Cancer
- ❑ STD
- ❑ Kidney Disease
- ❑ Ulcer

Musculoskeletal
- ❑ Ankylosis Spondylitis
- ❑ Fibromyalgia
- ❑ Muscular Dystrophy
- ❑ Osteoarthritis

Psychiatric
- ❑ Depression

Endocrine
- ❑ Insulin Dependent Diabetes
- ❑ Hormonal Dysfunction
- ❑ Thyroid Dysfunction
- ❑ Non-Insulin Diabetes

Blood/Lymphatic
- ❑ Large Volume Blood Loss
- ❑ Anemia

Allergy/Immunologic
- ❑ Environmental Allergies
- ❑ Rheumatoid Arthritis
- ❑ Drug Allergies
- ❑ Lupus

Other Problems
- ❑ Head trauma
- ❑ Other ____________________

____

____

Do you…

- Wear glasses? (circle one): Yes No If yes, which type? ❑ Single vision ❑ Bifocal ❑ Trifocal ❑ No-Line (Progressive)
- Wear sunglasses? Yes No
- Participate in sports/hobbies? Yes No If yes, what sports/hobbies? ______________________
- Work at a computer or use a handheld device? Yes No If yes, how many hours a day? For ________ hours a day
- Want to wear contacts? Yes No
- Wear contacts? Yes No If yes, what brand? ________________ Solution? ________________
- Sleep in your contacts? Yes No
  - Are you happy with your contacts? Yes No
  - How frequently do you change your contacts? Every ______ days / weeks / months

Authorization, Release, and Acknowledgment

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I acknowledge full financial responsibility for the services provided and also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the doctor.

I also acknowledge that Northpoint Eye Studio's Notice of Privacy Practices is available for me to read in the reception area at any time and copies will be given upon request.

Signature of Patient
(or parent/guardian, if minor) ______________________________________ Date ________________