IMAGINE
OPTOMETRY

PATIENT INFORMATION

Name: _____

Address: _____

City, State ZIP:_____

E-mail: _____

Gender ☐ F ☐ M Age: _____

Birthdate: _____/ _____/ _____

Race : ☐ Asian ☐ East Asian or Indian ☐ Hispanic or Latino
specify:_____

☐ White ☐ Black or African American ☐ Decline to *specify*

☐ Not listed *(specify)*: _____

Occupation / Field of Study: _____

Hobbies, Intersts, Sports: _____

Who may we thank for referring you?

☐ Advertisement ☐ Internet ☐ Patient

☐ Other: _____

PRIMARY INSURANCE

Member's Name: _____

Type of Vision Insurance: _____

Member's ID# or SSN: _____

Member's Birthdate: _____/ _____/ _____

Patient Relationship to Insured:

☐ Self ☐ Spouse ☐ Child

I understand that I am financially responsible for all fees for services provided and authorize payment of my medical benefits to IMAGINE Optometry for services rendered. If additional services are required (i.e. contact lens service, medical eye service), these may have additional charges not necessarily covered by insurance associated with them. All fees and insurance co-pays will be collected at the end of my visit.

Signature: _____ Date: _____

Print Name: _____

Relationship: ☐ Self ☐ Parent ☐ Guardian

PHONE NUMBERS

Mark best phone number to reach you:

☐ Home (____) _____ ☐ Cell (____) _____ ☐ Work (____) _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Phone (____) _____

EYECARE HISTORY

Date of Last Eye Exam: _____

Do you wear Glasses? ☐ Yes ☐ No

If yes, how old are your Glasses? _____

Do you plan to get new Glasses today? ☐ Yes ☐ No

Have you had Laser Refractive Surgery? ☐ Yes ☐ No

If no, are you interested in Refractive Surgery? ☐ Yes ☐ No

Do you wear Contact Lenses? ☐ Yes ☐ No

If yes, how old is your current pair? _____

If no, are you interested in Contact Lenses? ☐ Yes ☐ No

Do you experience symptoms of Dry Eye? ☐ Yes ☐ No

Office use only - SPEED Score: _____

- OVER -

OCULAR HEALTH & REVIEW OF SYSTEMS

Date of Last Physical Exam: _____ Type of Health Insurance: _____

Do you currently, or have ever had any problems in the following areas? Mark **Yes**, **No** or **Family**.
Marking **Family** would indicate you have a parent or sibling that currently has the listed condition.

Glaucoma	☐ Yes	☐ No	☐ Family
Macular Degeneration	☐ Yes	☐ No	☐ Family
Retinal Disease	☐ Yes	☐ No	☐ Family
Strabismus (eye turn)	☐ Yes	☐ No	☐ Family
Amblyopia (lazy eye)	☐ Yes	☐ No	☐ Family
Eye Injury	☐ Yes	☐ No	
Dry Eyes	☐ Yes	☐ No	
Double Vision	☐ Yes	☐ No	
Flashes / Floaters	☐ Yes	☐ No	
Eye Itch / Burn	☐ Yes	☐ No	
Eye Surgery	☐ Yes	☐ No	

If you answered **Yes** or **Family** to any of the above or have any other conditions not listed, please provide some additional details below:

_____

_____

_____

Do you use tobacco products? ☐ Yes ☐ No

Do you consume 2 or more alcoholic beverages per day? ☐ Yes ☐ No

Allergy / Immune (hay fever, immune deficiency)	☐ Yes	☐ No
Cardiovascular / Vascular (heart disease, high cholesterol / blood pressure)	☐ Yes	☐ No
Constitution (general illness / cancer)	☐ Yes	☐ No
Ear, Nose, Throat (sinus congestion, sore throat)	☐ Yes	☐ No
Endocrine (diabetes, thyroid, hormone dysfunction)	☐ Yes	☐ No
Gastrointestinal (chronic diarrhea, ulcers)	☐ Yes	☐ No
Genitourinary (kidney / bladder)	☐ Yes	☐ No
Hematologic / Lymphatic (anemia, bleeding problems)	☐ Yes	☐ No
Integumentary (rosacea, eczema)	☐ Yes	☐ No
Musculoskeletal (arthritis, back pain)	☐ Yes	☐ No
Neurological (headaches, migraines, seizures)	☐ Yes	☐ No
Psychiatric (depression, anxiety)	☐ Yes	☐ No
Respiratory (asthma, emphysema, chronic bronchitis)	☐ Yes	☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Are you nursing? ☐ Yes ☐ No

ALLERGIES

☐ No Known Drug Allergies ☐ Aspirin

☐ Latex ☐ Penicillin

☐ Seasonal Allergies ☐ Sulfa

☐ Other: _____

MEDICATIONS

List any medications you are currently taking and the corresponding health condition:

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosure in detail.

I acknowledge that I have received IMAGINE Optometry's Notice of Privacy Practices.

Signature: _____ **Date:** _____

☐ Patient ☐ Parent ☐ Guardian

Doctor's Signature: _____ **Date:** _____