If viewing this on your computer – you can CLICK ON each blank to enter your values.
***Then PRINT THE TWO PAGES and bring them with you to our office*. (E-Mail is not secure)**

(This is confidential information, you may leave anything blank if you choose.)

Name: ______________________ ***Main Phone:*** _______________ ☐Home ☐Cell ☐Work

Address: ______________________ ***Second Phone:*** _______________ ☐Home ☐Cell ☐Work

City, State, Zip: ______________________ ***Other Phone:*** _______________ ☐Home ☐Cell ☐Work

YOUR

Email address: ________________________

Social Security No. ______________

Date of Birth ___________ Gender: ☐M ☐F

Vision Benefit Plan: ____________________

Health Care Plan: ______________________

Would you like us to contact someone else if we have questions?

Name: _____________ Relation: ________

Their Phone: ___________ ☐Home ☐Cell ☐Work

OTHER PERSON (if applicable)

Who will be responsible financially, or is named as “insured”

Name: ___________Relation: _________

Street ________________________

City: _________ State:_____ Zip Code _____

Phone: ___________ ☐Home ☐Cell ☐Work

SSN: ____________ DOB:__________

Employer: ___________

SOCIAL HISTORY / INFORMATION:

Employer/Occupation______________________

____

____

Interests outside work: ______________________

____

Do you smoke? ☐No ☐Yes Drink Alcohol? ☐No ☐Yes

List any family that are also seen at this office:

____

____

____

NEW PATIENTS ONLY: What current patient referred you to our office?: ______________________

Date of Last Eye Examination: ___________ Where:___________ By Dr.: ___________

Do you wear contact lenses? ☐No ☐Yes : How Often/What Type? ______________________

Do you wear glasses? ☐No ☐Yes : How Often/What Type? ______________________

Do you use eyedrops? ☐No ☐Yes : How Often/What Type? ______________________

List any past surgeries, diseases or injuries to the eye(s):	Date	Surgeon/Physician

FAMILY MEDICAL HISTORY : Has your Mother, Father or Siblings ever had treatment for (please circle):

Blindness	Yes	No	Cataract	Yes	No	Glaucoma	Yes	No
Macular Degeneration	Yes	No	Retinal Detachment	Yes	No	Amblyopia /Lazy Eye/ Turned Eye	Yes	No
Diabetes	Yes	No	High Blood Pressure	Yes	No	Heart Disease	Yes	No
Thyroid Disease	Yes	No	Arthritis	Yes	No	Liver/Blood Diseases	Yes	No

Financial / Benefit Plan Information:

It is our office policy to expect payment at the time services are rendered. As a courtesy, we will process your benefit plan forms when it is applicable. If you have co-payments, deductibles or other charges outside or above what is determined to be the insurance company's responsibility, you will be responsible for those at this time.

AFTER YOU ARRIVE you will be asked to sign the following, indicating that you AGREE with the following statements:

- I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of benefits to Fig Garden Optometry Inc. for services and/or materials provided to me by them.
- I was offered a copy of Fig Garden Optometry Inc.’s Notice of Privacy Practices dated January 2, 2014 and signed the Acknowledgement form.

Signed: ______________________ Date: _____ / _____ / _____

<< TURN OVER TO ENTER PERSONAL MEDICAL INFORMATION >>

MEDICAL HISTORY/REVIEW OF SYSTEMS (Other than Eyes – which is with patient information):

What is your general health status? ☐Very Good ☐Good ☐Fair ☐Other:______________

Are you being treated or watched by a physician for any problems in the following areas?

If yes, please explain or describe the problem.

General / Constitutional **Yes / No**________________________________
(fever, weight loss or gain, tired feelings) ________________________________

Ears, Nose, Throat, Mouth **Yes / No**________________________________
*(hearing loss, cough, congestion, dry mouth)*________________________________

Cardiovascular **Yes / No**________________________________
(hypertension, heart problems, etc) ________________________________

Respiratory **Yes / No**________________________________
(asthma, emphysema, bronchitis, etc.) ________________________________

Gastrointestinal **Yes / No**________________________________
(diarrhea, constipation, hernia, ulcers, etc.) ________________________________

Genitourinary / Reproductive **Yes / No**________________________________
(painful/frequent urination, pregnancy, etc) ________________________________

Musculoskeletal **Yes / No**________________________________
*(arthritis, joint or muscle pain, stiffness, etc)*________________________________

Integumentary / Skin **Yes / No**________________________________
(pimples, warts, growths, rashes, impetigo) ________________________________

Neurological **Yes / No**________________________________
(dizziness, double vision, MS, migraines) ________________________________

Psychological **Yes / No**________________________________
(anxiety, depression, psychosis, etc.) ________________________________

Endocrine **Yes / No**________________________________
(diabetes, hormone/thyroid treatment, etc) ________________________________

Hematology / Lymphatic **Yes / No**________________________________
(anemia, bleeding problems, Hodgkins, etc.) ________________________________

Allergic / Immunologic **Yes / No**________________________________
(hayfever, atopy, other allergies) ________________________________

MEDICATIONS: Are you taking any prescription medications currently? ☐No ☐Yes, Please list below:

1	6	11
2	7	12
3	8	13
4	9	14
5	10	15

List any ALLERGIES or SENSITIVITIES to medications or substances:________________________________

____

If you are filling this form out for the FIRST TIME, do not enter anything below.

Date:	**Any Changes to Personal, Social, Medical or Family Information?**	**Patient Sig.**	**Doctor Sig.**

For Doctor:
The information on both sides of this page has been reviewed by -*______________________________Date:***____________________