Albright EYECARE

Douglas B. Albright, O.D., F.A.A.O.

Please fill in all blanks on both sides to the best of your ability and sign where designated.

Name _____ Date _____

SSN _____/_____/_____ DOB ____/____/____ Age _____

Home Phone _____ Work Phone _____ **Cell Phone** _____

Email _____

Address _____ City _____ State _____ Zip _____

Sex M F Marital Status: Single Married Divorced Widowed Separated

How did you find us? Insurance Phone Book Internet Friend _____ Other _____

Employer _____ Occupation _____

Employer Address _____ City _____

If a student, name of school _____ Retired: Y N

Primary care physician _____ Spouse or Parent's Name _____

In case of emergency, contact _____ **Relation** _____

Primary Phone # _____ **Secondary #** _____

RESPONSIBLE PARTY

Name _____ Relation _____

Employer _____ Occupation _____

Employer Address _____ City _____

SSN _____/_____/_____ DOB ____/____/_____ Phone _____

A 3% usage fee will be collected on all credit card transactions. There is no usage fee for cash or check.

INSURANCE INFORMATION

Please have insurance card ready to make a copy

Medical Insurance Y N Company _____ Policy # _____

Vision Insurance Y N Company _____ Policy # _____

Medicare Y N If so, co-insurance Y N Company _____

I authorize the release of any medical information necessary to process all claims and the release of payment for medical benefits to my physician. I acknowledge I will be responsible for any services my insurance does not cover including refractions.

Patient's Signature or representative _____ Date _____

HEALTH HISTORY

Reason for today's exam? _____

How long ago did the problem start? _____

Date of last exam _____ Name of previous Eye doctor _____

Do you currently wear glasses? Y N if so, for what? Distance Reading Driving Computer

Do you work on a computer? Y N if so, how many hours per day? _____

PAT # _____ APPT: _____ INS: _____ Rm:_____

Albright EYECARE

Douglas B. Albright, O.D., F.A.A.O.

HEALTH HISTORY CONTINUED

Do you wear contact lenses? Y N if so, what kind? _____

Are you interested in contact lenses? Y N

Are you interested in laser vision correction? Y N

Smoker? Y N how many packs per day? _____

Alcohol? Y N how many drinks per week? _____

What hobbies or sports do you participate in? _____

Current Medications being taken:

_____

_____

_____

_____

Allergies to anything:

_____

_____

_____

_____

Circle if you or your family have a history of the following: S = self F = family (identify family relationship)

Allergies	S	F	_____	Flashes of light	S	F	_____	Pupil Dysfunction	S	F	_____
Amblyopia	S	F	_____	Floaters	S	F	_____	Pregnant	S		
Arthritis	S	F	_____	Frequent Headaches	S	F	_____	Retinal Detachment	S	F	_____
Burning Eyes	S	F	_____	Glaucoma	S	F	_____	Retinitis Pigmentosa	S	F	_____
Blindness	S	F	_____	High Blood Pressure	S	F	_____	Retinopathy	S	F	_____
Cancer	S	F	_____	Keratoconus	S	F	_____	Strabismus	S	F	_____
Cataract	S	F	_____	Lazy Eye	S	F	_____	Stroke	S	F	_____
Color Deficiency	S	F	_____	Lupus	S	F	_____	Sjogren's	S	F	_____
Diabetes	S	F	_____	Macular Degeneration	S	F	_____	Thyroid	S	F	_____
Dry Eye Syndrome	S	F	_____	Migraines	S	F	_____	Vascular Disease	S	F	_____
Excessive Tearing	S	F	_____	Ocular Infection	S	F	_____	Double Vision	S	F	_____
Eye Surgery	S	F	_____								

Past Medical History:

_____

_____

_____

Past Surgical History:

_____

_____

_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me, or my child during the period of such eye care to third party payers. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on behalf of my dependants.

Sign: _____ Date: _____