OCULIST OPTIQUE
See Well, Live Better

Welcome to our practice!
The information provided on this form helps us provide the best possible care. Please fill it out to the best of your ability. Thank you!

Name: _____ _____ ____ Date of Birth: ___/___/___
First Last MI

Address: _____ Sex: ☐M ☐F
Street

_____ _____ _____ SSN: _____
City State Zip

Home: _____ Email: _____

Cell: _____ Occupation: _____

Work: _____ Employer: _____

Notify in Emergency: _____ Phone: _____

Reason for visit today:
☐ Annual Eye Exam ☐Contact Lens Exam
☐Vision Problem ☐LASIK Evaluation
☐Other: _____

Date of last eye exam: _____
Name of Doc: _____

Do you wear glasses? ☐Yes ☐No

Do you wear contacts? ☐Yes ☐No
Contacts Type: ☐Soft ☐Hard ☐RGP
Sleep in your lenses? ☐Yes ☐No
I replace my lenses every: ☐day ☐week ☐month ☐year
Do you work on a computer? ☐Yes ☐No

Insurance Information:
Vision Insurer: _____
Member ID: _____

Medical Insurer: _____
Member ID: _____

Policy Holder Name: _____
DOB: ___/___/___ SSN: _____
Relation to Patient: _____

I understand that I am personally responsible for all charges for services rendered by this practice, whether or not paid by insurance. I hereby authorize Oculist Optique and Dr. Jaillet to release all information necessary to secure payment of benefits. This authorization pertains to all insurance submissions.

_____ _____
Signature Date

Medical History

Please indicate if you have had any of the following:

Hearing Loss	☐Yes	☐No	Fibromyalgia	☐Yes	☐No
Depression	☐Yes	☐No	Osteoarthritis	☐Yes	☐No
Hypertension (high blood pressure)	☐Yes	☐No	Muscular Dystrophy	☐Yes	☐No
Heart Disease	☐Yes	☐No	Arthritis	☐Yes	☐No
Congestive Heart Failure	☐Yes	☐No	Rosacea	☐Yes	☐No
Stroke	☐Yes	☐No	Psoriasis	☐Yes	☐No
Smoke	☐Yes	☐No	Eczema	☐Yes	☐No
Emphysema	☐Yes	☐No	Thyroid dysfunction	☐Yes	☐No
Chronic Bronchitis	☐Yes	☐No	Diabetes	☐Yes	☐No
Asthma	☐Yes	☐No	Anemia	☐Yes	☐No
Ulcers	☐Yes	☐No	High Cholesterol	☐Yes	☐No
Chrohn's Disease	☐Yes	☐No	Seasonal Allergies (Hay fever)	☐Yes	☐No
Colitis	☐Yes	☐No	Lupus	☐Yes	☐No
Prostate Disease	☐Yes	☐No	Drug Sensitivity	☐Yes	☐No
Kidney Disease	☐Yes	☐No	Drug Allergies	☐Yes	☐No
Chlamydia	☐Yes	☐No	Food Allergies	☐Yes	☐No
Surgery	☐Yes	☐No			

Medications

List any prescription or non-prescription medications

_____
_____
_____
_____

Allergies

List all known allergies:

_____
_____
_____
_____

Eye Health History

Please indicate if you or a member of your immediate family have had:

	Self		Family	
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No
Inflammation of the eye	☐ Yes	☐ No	☐ Yes	☐ No
Age-related Macular Degeneration	☐ Yes	☐ No	☐ Yes	☐ No
Amblyopia	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No
Strabismus	☐ Yes	☐ No	☐ Yes	☐ No
Retinal Degeneration	☐ Yes	☐ No	☐ Yes	☐ No
Detached Retina	☐ Yes	☐ No	☐ Yes	☐ No
Corneal Ulcer	☐ Yes	☐ No	☐ Yes	☐ No

Has any member of your family ever had:

Thyroid Disease	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Smoking	☐ Yes	☐ No

Do you drink alcohol? ☐ Yes ☐ No
How often? _____ How much? _____

Do you smoke tobacco? ☐ Yes ☐ No
How often? _____ How much? _____

Are you pregnant? ☐ Yes ☐ No

Initials	
	It may be necessary to dilate your pupils during the course of your examination. Dilation results in light sensitivity and may cause a temporary inability to see at close range. These side effects typically last from three to five hours. If you do not have sunglasses we will provide you with a pair of disposable sunglasses.
	A new, highly sophisticated, computerized instrument now allows us to provide you with a more thorough medical analysis of your eye health. The **digital retinal imaging system** takes photographs of your retina (the back of your eye). The procedure assists the doctor in the early detection of many disorders, including cataracts, glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. The images are stored in the computer and compared with images from future exams. This allows the doctor to observe even the smallest change from the previous exam. Most vision insurance plans DO NOT cover this procedure. Oculist Optique charges $39 for this service. ☐ I choose to have Baseline Digital Retinal Images taken & evaluated **for an additional fee of $39**. ☐ I decline this test.
	I hereby give my consent for **Oculist Optique** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Oculist Optique** describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. Oculist Optique reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **the Office Manager at Oculist Optique (678) 393-9445.** With this consent, **Oculist Optique** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO and may mail to my home or other alternative location any items that assist the practice in carrying out TPO as long as they are marked "Personal and Confidential." With this consent, **Oculist Optique** may e-mail any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Oculist Optique** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to allow **Oculist Optique** to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Oculist Optique** may decline to provide treatment to me.

_____ _____ _____

Signature of Patient or Guardian | Printed Name | Date