WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MEDICAL INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST

Please Print

Patient's Legal Name: _____

Guardian Name: _____ **Marital Status** ❑ **M** ❑ **S** ❑ **D** ❑ **W**

DOB _____/_____/_____ **SSN#** _____/_____/_____

Address _____

City/St _____ **Zip** _____

Home Phone _____

Cell Phone _____

Occupation _____

Email _____

Primary Insured _____

DOB _____/_____/_____

SSN# _____/_____/_____

Insurance Company _____

Member ID# _____

Miscellaneous

Last Eye Exam _____/_____/_____

Are you followed by an Ophthalmologist? ❑ **Yes** ❑ **No**

If so, Whom? _____

Do you wear glasses? ❑ **Yes** ❑ **No**

***Do you wear contact lenses?** ❑ **Yes** ❑ **No**

***Are you interested in contact lenses?** ❑ **Yes** ❑ **No**

*Additional fee for evaluation

How did you hear about us? _____

Are there any specific optical products/brands that you are interested in? ❑ **Yes** ❑ **No**

Are you interested in refractive surgery? ❑ **Yes** ❑ **No**

Do you have trouble reading signs when driving at night? ❑ **Yes** ❑ **No**

Are you bothered by glare from: Overhead lighting? ❑ **Yes** ❑ **No**

A computer screen? ❑ **Yes** ❑ **No**

Oncoming headlights at night? ❑ **Yes** ❑ **No**

Are you sensitive in bright sunlight? ❑ **Yes** ❑ **No**

Are you Pregnant? ❑ **Yes** ❑ **No**

Are you Breastfeeding? ❑ **Yes** ❑ **No**

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Fever, Weight Loss/Gain	❑	❑
Cardiovascular		
Heart Disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Stroke	❑	❑
Vascular Disease	❑	❑
Ears/Nose/Mouth/Throat		
Allergies	❑	❑
Sinus Congestion	❑	❑
Hearing Loss	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Sleep Apnea	❑	❑

	Yes	No
Gastrointestinal		
Crohn's Disease	❑	❑
Hepatitis A	❑	❑
Hepatitis B	❑	❑
Hepatitis C	❑	❑
Ulcer/Reflux	❑	❑
Genito-Urinary		
Bladder/Genital/Kidney	❑	❑
Herpes Simplex	❑	❑
Prostate	❑	❑
Musculoskeletal		
Joint/Muscle Pain	❑	❑
Osteo Arthritis	❑	❑
Rheumatoid Arthritis	❑	❑
Integumentary (skin)		
Skin Cancer	❑	❑
Herpes Zoster/Shingles	❑	❑

	Yes	No
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Multiple Sclerosis	❑	❑
Gout	❑	❑
Seizures	❑	❑
Psychiatric		
Anxiety/Depression	❑	❑
Endocrine		
Diabetes Type I	❑	❑
Diabetes Type II	❑	❑
Thyroid/Other Glands	❑	❑
Lymphatic - Hematologic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic/Immunologic		
Eczema	❑	❑
Hives	❑	❑
Lupus	❑	❑
Organ transplant	❑	❑

Please Complete Both Pages of the Form →

Ocular History

Age-related macular degeneration	❑ Yes	❑ No
Amblyopia (Lazy eye)	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Cataract Surgery	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
History of refractive surgery	❑ Yes	❑ No
Strabismus (Crossed eyes)	❑ Yes	❑ No
Tear film insufficiency (Dry eyes)	❑ Yes	❑ No

Other _____

_____

Family Health History

(Mark yes or no to each entry. If yes, list which family member including, mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather.

Amblyopia (Lazy eye)	❑ Yes	❑ No _____	Strabismus (Crossed eyes)	❑ Yes	❑ No _____
Blindness and/or vision impairment	❑ Yes	❑ No _____	Arthritis	❑ Yes	❑ No _____
Cataract	❑ Yes	❑ No _____	Cancer	❑ Yes	❑ No _____
Macular Degeneration	❑ Yes	❑ No _____	Diabetes	❑ Yes	❑ No _____
Glaucoma	❑ Yes	❑ No _____	Hypertension (High blood pressure)	❑ Yes	❑ No _____
Retinal disorder	❑ Yes	❑ No _____	Cardiovascular disease	❑ Yes	❑ No _____
			Stroke	❑ Yes	❑ No _____

Social History (check one for each question)

Are you a drug user? ❑ Yes ❑ No

Are you a: ❑ Non-drinker ❑ Social drinker

Tobacco Use (mark which one applies)

❑ Heavy tobacco smoker ❑ Light tobacco smoker

❑ Never a smoker ❑ Former smoker

Medications

- ❑ Will Discuss with Doctor
- ❑ Permission given to pull Medication List from Pharmacy
- ❑ Taking any over the counter medications
- ❑ No Prescribed Medications

Medication Allergies

List any allergies you may have:

_____

_____

❑ **No Medication Allergies**

I hereby authorize KORRECT OPTICAL / THE DOCTORS to furnish information to insurance carriers on my behalf and I hereby assign to the doctor all payment for routine/ medical services pertaining to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. I understand that I am responsible for any fees or charges for services and/or materials. **Payment is requested at time of service. We accept cash, check, CareCredit™ and all major credit cards.**

Signature _____ Date _____

Routine eye exams are typically not covered under your medical Insurance and therefore will need to be billed to a separate Vision Plan or paid in full at the time of service. Medical eye exams must be billed to your Health Insurance carrier. Any deductibles, refraction fees and co-pays will be billed to you.