PLEASE PRINT on this form as completely as possible **Date:**_____
*Please have your **medical insurance card** ready*

Last Name _____ E-mail _____

First Name _____ MI _____ Date of Birth_____ Age_____

Prof / Mr. / Mrs. / Ms / Miss / Dr. (Please circle one) Employer_____

Address_____ Occupation _____

City_____ZIP_____ Primary Care Physician (PCP) _____

Home Phone (_____) _____ **Vision Insurance**_____

Mobile Phone (_____) _____ **Vision Ins**. Member ID/SSN# _____

Medical PPO Ins. _____ **Medical Ins**. ID# _____ Group # _____

Primary Member's Full Name _____ **Primary Member's** DOB _____

Pref. Language _____ Race ❑Am. Native ❑Asian ❑African Am. ❑Hispanic ❑Pacific Islander ❑White ❑Decline

Date of last eye exam _____ What is the main reason for today's visit? _____

Have you ever worn glasses? ❑Yes ❑No Have you had OR are you interested in refractive surgery? ❑Yes ❑No

Have you ever worn contacts? ❑Yes ❑No Have you had problems wearing contacts? ❑Yes ❑No

Have you ever had vision therapy? ❑Yes ❑No How did you hear about our office? _____

HEALTH HISTORY - *Please check the conditions that apply to you and your family, and specify relationship.*

Medical History

Allergies	❑ Self	❑Family _____
Diabetes	❑ Self	❑Family _____
Drug sensitive	❑ Self	❑Family _____
Head trauma	❑ Self	❑Family _____
Heart disease	❑ Self	❑Family _____
High cholesterol	❑ Self	❑Family _____
High blood Pressure	❑ Self	❑Family _____
Migraine or Headaches	❑ Self	❑Family _____
Respiratory disease	❑ Self	❑Family _____
Thyroid	❑ Self	❑Family _____

Eye History

Cataracts	❑ Self	❑Family _____
Color "blind"	❑ Self	❑Family _____
Diabetic Retinopathy	❑ Self	❑Family _____
Dry eyes	❑ Self	❑Family _____
Glaucoma	❑ Self	❑Family _____
Floaters/spots	❑ Self	❑Family _____
Flashing lights	❑ Self	❑Family _____
Lazy eye / Turned eye	❑ Self	❑Family _____
Macular Degeneration	❑ Self	❑Family _____
Retinal detachment	❑ Self	❑Family _____

Are you currently under a physician's care? ❑No ❑Yes, Please specify (i.e. pregnancy) _____

Current medications _____

Do you have any allergies to medications/NON-medication? ❑No ❑Yes, please specify _____

Do you use tobacco? ❑ Never ❑ No, I quit. ❑ Yes Do you use alcohol? ❑ Never ❑ No ❑ Yes

Communications Authorization: I give permission to Gary Sneag, O.D. Optometric Corporation and staff to contact me regarding issues of health and eye care by mail, phone, and/or email and may opt out by written request. **Patient or Guardian Initials**_____

Insurance Disclaimer: I understand I am financially responsible, whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should such court action be required. **Patient or Guardian Initials**_____

Acknowledgement of our Notice of Privacy Practices: I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Gary Sneag, O.D. Optometric Corp - Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices. **Patient or Guardian Initials**_____

I acknowledge that photostatic copies of these acknowledgements will be considered as valid as the original.

Print Name _____ **Signature** _____ **Date** _____