ANN ARBOR optometry

Name:_____ Sex at Birth: ☐ Male ☐ Female

Address: _____ Date of Birth: _____

City/State/Zip: _____ Primary Phone: _____

SSN: _____ Email: _____ Secondary Phone: _____

Parents' name (if minor): _____ ☐ Single ☐ Married ☐ Life Partner

Employer: _____ Occupation: _____ ☐ Full time ☐ Part time ☐ Full-time Student

In accordance with the new healthcare guidelines, we are required to obtain the following information:

Preferred Language: ☐ English ☐ Spanish ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic

☐ Native Hawaiian or Other Pacific Islander ☐ Not Disclosed ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Not Disclosed ☐ Not Hispanic or Latino

Communication Preference: ☐ Telephone ☐ Email ☐ Mail

Vision Insurance Co: _____ Subscriber: _____ DOB: _____

Contract #: _____ Group #: _____

Subscribers address if different from patient:_____

Medical Insurance Co: _____ Subscriber: _____ DOB: _____

Contract #: _____ ☐ HMO ☐ PPO ☐ Traditional Group #: _____

Subscribers address if different from patient:_____

*Please give your medical insurance card to the front desk

I wear glasses: ☐ yes ☐ no I have had laser corrective surgery: ☐ yes ☐ no I am interested in LASIK? ☐ yes ☐ no

I wear contact lenses: ☐ yes ☐ no Type: _____ I replace my contacts every: _____

When was your last eye exam? _____ Name of previous eye doctor: _____

Referred by: _____ ☐ Doctor ☐ Friend ☐ Family ☐ Insurance co. ☐ Advertisement

Due to the Health Insurance Portability and Accountability Act your initials & signature are required below

INITIALS:

☐ I *authorize* any holder of medical information about me to release to my insurance company or its agent any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized services be made on my behalf to Ann Arbor Optometry. I agree to be personally and fully responsible for co-pays, deductibles, non-covered and denied services by my insurance company.

OR

☐ I *decline* the above information release and am solely responsible for fees. I understand that fees are due at time of service.

AND

☐ I authorize any holder of medical information about me to release and/or request my medical information with other health care professionals for the purpose of consultation and referral as appropriate for my health care.

☐ I have been provided the Ann Arbor Optometry Privacy Policy. [You may request a copy for your records]

Signature: _____ Relationship to patient: _____ Date: _____

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Patient Name: _____

Primary Care Doctor: _____ Office Phone Number: _____

Hobbies, special vision needs: _____

_____

Please list any medications: _____

_____

_____

Height: _____ft. _____in. Weight:_____lbs

Please list any allergies (medical & general): _____

_____

Do any of the following conditions apply to you:

☐ Constitutional (fever, weight change)	☐ Ear/Nose/Mouth/Throat	☐ Skin Condition
☐ Stomach or Gastrointestinal	☐ Kidney or Liver	☐ Lung or Respiratory
☐ Asthma	☐ Diabetes	☐ High cholesterol
☐ Psychological	☐ Blood disorder	☐ Headaches
☐ Multiple sclerosis	☐ Arthritis or joint	☐ Thyroid
☐ Cancer	☐ Immune deficiency	☐ Pregnant
☐ Cataracts	☐ Macular degeneration	☐ Glaucoma
☐ Lazy eye or eye turn	☐ Retinal detachment	☐ Dry eye
☐ Eye injury	☐ Eye surgery	☐ Head injury
☐ Tobacco: ☐light ☐mod ☐heavy	☐ Alcohol: ☐light ☐mod ☐heavy	☐ Drug use: ☐light ☐mod ☐heavy

If you indicated any of the above conditions apply to you, please explain and list treatment:

Please list any other health conditions:

_____

_____

_____

Does your family history include any of the following? If yes, what is their relationship to you?

	Relationship:		Relationship:
☐ Glaucoma	_____	☐ High Blood Pressure	_____
☐ Cataracts	_____	☐ Heart Disease	_____
☐ Macular Degeneration	_____	☐ Diabetes	_____
☐ Retinal Detachment	_____	☐ Thyroid Condition	_____
☐ Blindness	_____	☐ Other	_____

Signature_____ Relationship to patient _____