Welcome to our Office

Name:_____Date:____/____/____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:____/____/____ Age:_____ Daytime/Cell Phone#: _____

Email Address: _____

How long since your last eye exam?_____ Whom may we thank for your visit?_____

Reason for your visit today?:_____ Occupation/Employer: _____

Vision Insurance Provider: _____ Last 4 digits of your SSN:_____

Primary Insurance Holders Name: _____

Date of Birth:____/____/____ Last 4 of their SSN:_____

Do you currently wear glasses? Yes No Do you currently wear contact? Yes No

History: Check any conditions that pertain to you now or in the past:

___ Asthma	___Eye Surgery	___Headaches/Migraines	___MS
___Blurred Vision	___Diabetes	___Heart Disease	___Retinal Disease
___Cataract	___Double Vision	___Hypertension	___Thyroid
___ Eye Infection	___Floaters	___Loss of Vision	___Crossed/Lazy Eye
___Eye Injury	___Glaucoma	___Macular Degeneration	

Family History: Check any conditions that family members have now or have had in the past:

___ Glaucoma ___Blindness ___Diabetes ___Macular Degeneration

Medications: Please list all medications you are currently taking:_____

_____

Are you allergic to any medications?_____ If so please list: _____

HIPAA Privacy Policy

I acknowledge that I have viewed the Notice of Privacy Practices for the doctors of Professional Vision Care at Optique of Denver.

Signature: _____ Date:____/____/____

Authorization to Release Identifying Medical Records

I authorize Optique of Denver to release health information identifying me, including but not limited to prescriptions, exam history, invoices and exam history & notations via email, fax, or mail at my request.

Signature: _____ Date:____/____/____