WELCOME

Speak Eyecare & Designer Optical

Date:_____ **Name:**_____

Welcome to our Practice today! Please take a moment to fill in or update your history for us. Thank you.

PATIENT INFORMATION:	**PAYMENT/INSURANCE INFORMATION: ↓ *REQUIRED INFO* ↓**
Name:	**Please Check √ IF NO INSURANCE → → □–NONE**
First Middle Last	**Account Balance Responsible Party?**
Preferred Name:	**Insurance Cardholder Name:**
Address:	**Cardholder → Birthdate: →SS#:**
City: State:	**Is Patient covered by another Insurance?(√) □–Yes □–No □–N/A**
Zip Code:	***If Yes, please list:***
Email:	**Policy/Group #:**
Phone Home #:	**Medicare Secondary Insurance:(√) □–Yes □–No □–N/A**
Cell #: Work #:	***If Yes, please list:***
Please (√) Below: *(*Info Required for Insurance)*	**Policy/Group #:**
Sex:□–M *or* □–F Birthdate: Age:	**Note: Please provide Patient's Medical Insurance Card for verification of any vision or medical coverage. Many "routine" exams become medical exams based on the doctor's findings during your exam.**
□–Minor □–Single □-Married □-Divorced	
□-Separated □-Widowed □-Domestic Partner	
Patient Occupation:	**Insurance/Payment Information**
Patient Employer/School:	**Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. ↓ I understand I am responsible for ANY BALANCE DUE. ↓**
Employment: □–Full Time *or* □–Part Time	
Parent/Spouse/Partner Name:	
Parent/Spouse/Partner Birthdate:	
Parent/Spouse/Partner SS#:	
Parent/Spouse/Partner Employer:	**Please Check √ and Initial you understand the Payment Responsibility for today's charges: → □ _____**
Parent/Spouse/Partner Work/Cell #:	
Emergency Contact/Name:	**ACKNOWLEDGEMENT OF RECEIPT & REVIEW OF PRIVACY PRACTICES**
Emergency Contact/Phone:	
Please √ Correct Answers Below:↓ *REQUIRED INFO* ↓	I acknowledge that I have received or had an opportunity to review a copy of Sheri L. Speak, O.D.'S, Notice of Privacy Practices.
Preferred Language(√ One):□-English *or* □- Spanish	
Race (√ One):□-American Indian or Alaska Native	
□-Asian	**Patient Name *(Please Print):***
□-Black or African American	**Patient Signature:**
□-Hispanic	**Date:**
□-Native Hawaiian/Other Pacific Island	
□-Other	**REASON FOR YOUR VISIT TODAY**
□-White	**ROUTINE VISITS: *Please Check √ ALL that Apply to Patient***
Ethnicity (√ One): □-Hispanic *or* Latino	□-Annual Eye Examination
□-Native Hawaiian/Other Pacific Island	□-Contact Lens Fitting-*New Wearer*
□-Not Hispanic or Latino	□-Contact Lens Fitting-*Previous Wearer*
Communication Preference (√ One): □-Email	□-Contact Lens Fitting-*Color Changing*
□-Postal *or* □–Telephone	□-Refractive Surgery Evaluation
Referred by (√ One): □-Patient □-Professional □-None	**Please list any additional concerns:**
Please List Name of Referral:	
Patient 18 Years & Older SSN:	

PATIENT EYE SURGERY HISTORY	**MEDICAL EXAMINATIONS & SPECIAL TESTING:**
□-None □-RK □-Cornea Transplant	□-Cataract Assessment □–OCT Testing

□-Cataract □-Glaucoma Surgery	□-Diabetic Examination	□-Physician Referral-*Please List Name*
□-Lasik □-Retinal Surgery □-Yag	□-Dry Eye Evaluation	Dr. _____
Date(s) of Surgeries:	□-Eye Infection/Irritation	□-Plaquinel Examination
	(Allergy/Infection/Injury/Stye)	□-Tamoxifen Examination
	□-Glaucoma Examination	□-Visual Field Examination

PATIENT EYE HEALTH HISTORY: *Please Check √ ALL of the following that apply to Patient*

□-Blinking	□-Glare/Halos	□-Ocular Fatigue
□-Color Problems	□-Headaches	□-Poor Night Vision
□-Computer Issues	□-Head Tilt or Turn	□-Pushing Reading Out
□-Depth Perception	□-Intermediate Vision	□-Shadows
□-Distance Vision	□-Light Sensitivitiy	□-Squinting
□-Double Vision	□-Must Take Off RX to Read	□-Stopped Driving
□-Eyestrain	□-Near Vision	*Date?* _____
□-Fatigue	□-Need More Light	

FAMILY EYE HEALTH HISTORY: *Please Check √ ALL that apply to Immediate Family Only (Grandparents, Parents, Siblings)*

□-Blindness □-Glaucoma □-Macular Degeneration □-Retinal Problems *Other*: _____

PATIENT HEALTH HISTORY: *Please Check √ ALL that apply to Patient*	**ORAL MEDICATIONS:**
□-None □-Auto Immune Disorder □-Cancer □-Diabetes	□√ **Check Here if NO Medications or List Below:**
□-Graves Disease □-High Blood Pressure □-High Cholesterol	
□-Sarcoid □-Sjogrins □-Thyroid Problems *Other:* _____	
Social Hx: **Please Check √** □-Nonsmoker □-Smoker/Amt. _____	
□-Nondrinker □-Drinker/Amt. _____	

DRUG ALLERGIES:	□√ **Check Here if NO Allergies or List:**
EYE MEDICATIONS:	□√ **Check Here if NO Eye Meds or List:**

CURRENT GLASSES/RX STATUS:	**CURRENT CONTACT LENS WEARER STATUS:**
Do you currently have glasses? Y / N How old?	Current Brand:
STATUS: Having problems with current pair? Y / N	Current RX:
□-Broke □-Dog Ate Them! □-Lost □-Use/Backup	How often do you replace them? **Please Check √**
CONTACT LENS WEARER: *Please Check √*	□-Daily □-2 Weeks □-Monthly □-3 Months □–Yearly
□-Decreased Distance □-Dryness □-Eyes Burn	Solutions: □-Optifree □-Clear Care □-Generic □-Other
□-Near Vision Issues □-Poor Comfort	Wearing Time: □-Remove Daily *or* □-Sleep in Them
□-Solutions Burn	

↓ For Staff Use Only ↓

Additional Staff Notes: