Optical Gallery

(Office Use only)
CL New I/R Optos W
CL Established F/U Optos M

Last Name_____ First Name _____ MI_____ DOB ___/___/____
M or F Preferred Pronouns _____ Marital Status: Married / Single / Divorced / Widowed
Address_____ City_____ State_____ Zip_____
Phone number (personal)_____ Phone number (work)_____
Email Address_____ Sports/ Hobbies_____
Preferred Method of Contact: ☐Email (above) ☐Phone Call _____☐Text_____
Employer/School_____ Occupation/School Grade_____
Emergency Contact Name and Phone number_____

****Please give your insurance card to the front desk****

Date of Last Medical Exam (approx)_____ Primary Physician/Clinic_____
Date of Last Eye Exam (approx, if elsewhere) _____ Clinic/Eye Doctor_____

Visual (with glasses/Contacts)

Blurred Vision ☐
Loss of Vision ☐
Double Vision ☐
Flashes ☐
Floaters ☐
Dryness ☐
Watering ☐
Irritation ☐
Redness ☐
Itching/burning ☐
Pain/soreness ☐
Light sensitivity ☐
Eye strain/fatigue ☐
Halos/glare ☐
Poor color vision ☐
Headaches ☐
History of eye trauma ☐
History of eye surgery ☐

Previous diagnosis of:
Cataracts ☐
Glaucoma ☐
Retinal detachment ☐
Macular degeneration ☐

Other_____

Medical History

High blood pressure ☐
Stroke ☐
Heart Disease ☐
High cholesterol ☐
Diabetes ☐
Thyroid problem ☐
Asthma ☐
Emphysema ☐
COPD ☐
Cancer ☐
Type_____
ADHD ☐
Depression ☐
Schizophrenia ☐
Autism ☐
Multiple Sclerosis ☐
Epilepsy ☐
Auto-Immune ☐
Type_____
Fibromyalgia ☐
Sjogren's syndrome ☐
AIDS/HIV ☐

Other_____

Family History

Cataracts ☐
Glaucoma ☐
Retinal detachment ☐
Macular degeneration ☐
Blindness ☐
Crossed Eyes ☐

Diabetes ☐
Cancer ☐
Heart disease ☐
Other_____

Are you pregnant or nursing? Yes No N/A
Alcohol Use? Yes No
Amount_____
Tobacco Use? Yes No
Amount_____

Medications ☐ See medication list

- _____For_____
- _____For_____
- _____For_____
- _____For_____
- _____For_____
- _____For_____

Allergies (Medication or environmental/seasonal)
_____
_____

Insurance Authorization/ HIPAA Notice
I authorize the release of any information, including the diagnosis and any treatment or exam rendered to me or my child during the period of such care, to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the bill for services. I agree to be responsible for payment of all services rendered on my behalf or dependent.
I acknowledge that I had the opportunity to review and have received a copy (if so desired) of Optical Gallery's Notice of Privacy Practices

Signature_____ Date_____

*For next years visit: I have verified that no iinformation above ha changed.
Initials_____ Date_____