Exam Date: Date: Date: Date: Date:

Patient's Name: Patient's DOB: Female

Patient's Address: City/State/Zip: / /

Patient's Phone: Email:

Sponsor's Name: Sponsor's DOB:

Sponsor's SSN/Patient's DBN: Sponsor's Phone:

Sponsor's Address (if different from patient):

Patient's relationship to Sponsor (dropdown): Spouse

Has the patient ever worn (dropdown): None

Approximate date of last exam:

Reason for visiting today:

- ☐ Annual Examination
- ☐ Lost or broken glasses/Want new glasses
- ☐ Want contacts/Change eye color
- ☐ Blurred distance/Near vision
- ☐ Headaches/Fatigue

Other:

Family History (include relationship):

- ☐ **None apply**
- ☐ Glaucoma PGF
- ☐ Cancer PGF
- ☐ Diabetes PGF
- ☐ Thyroid PGF
- ☐ Retinal Disorder PGF
- ☐ Macular Degeneration PGF
- ☐ High Blood Pressure PGF
- ☐ Heart Disease/Stroke PGF
- ☐ Color Deficiency PGF

Other:

Medications the patient is taking (i.e. oral contraceptives, aspirin, over the counter medication, & home remedies):

List anything the patient is allergic to:

List any major eye injuries or eye surgeries the patient has had:

Does the patient have health coverage under another health plan? No

If you have another health insurance plan, Tricare will automatically become secondary. Payment will be due at the time of your eye exam, as your primary insurance must be billed first. All insurance patients: I am aware that I am responsible for any examination fee not covered by my insurance, and I acknowledge that I have been offered a copy of the privacy notice, and I authorize Family Optometric Associates, P.C. to release my medical record to Tricare/insurance company.

By signing below, I authorize Family Optometric Associates, P.C. to disclose my health information as needed for continuity of care by my verbal consent. This may be revoked only by a written or electronic note.

Patient's signature (parent, if minor): x _____

Patients, please turn this form over and complete side 2

For office use only

	DOS:	RX	Ins: TPA	CPT: 92004	Dx:	Verify:	Tech:
x:	DOS:	CLE/RX	Ins:	CPT:	Dx:	Verify:	Tech:
x:	DOS:	CLE/RX	Ins:	CPT:	Dx:	Verify:	Tech:
x:	DOS:	CLE/RX	Ins:	CPT:	Dx:	Verify:	Tech:

Office: Pearl Harbor

What is the patient's occupation?

How many hours are you on a computer/phone/tablet per day?

How did you hear about us?

Are you pregnant or nursing (dropdown): None

Review of Systems— Do you currently, or have you ever had any problems in the following areas?

☐ **No current health problems**

Eyes
- ☐ **None**
- ☐ Loss of vision
- ☐ Blurred vision
- ☐ Dryness
- ☐ Mucous discharge
- ☐ Redness
- ☐ Sandy/gritty
- ☐ Itching/burning
- ☐ Chronic lid/eye infection
- ☐ Sty/chalazion
- ☐ Flashes/floaters

Constitutional
- ☐ **None**
- ☐ Fever
- ☐ Weight loss/gain

Integumentary
- ☐ **None**
- ☐ Skin

Neurological
- ☐ **None**
- ☐ Headaches
- ☐ Seizures

Allergic/Immunologic
- ☐ **None**

Ears/Nose/Mouth/Throat
- ☐ **None**
- ☐ Allergies/hay fever
- ☐ Sinus congestion
- ☐ Dry throat/mouth

Endocrine
- ☐ **None**
- ☐ Diabetes
- ☐ Thyroid/other glands

Gastrointestinal
- ☐ **None**
- ☐ Diarrhea
- ☐ Constipation

Respiratory
- ☐ **None**
- ☐ Asthma
- ☐ Emphysema

Vascular/Cardiovascular
- ☐ **None**
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Vascular disease

Genitourinary
- ☐ **None**
- ☐ Genitals/kidney/bladder

Bones/Joint/Muscles
- ☐ **None**
- ☐ Rheumatoid arthritis
- ☐ Joint/muscle pain

Lymphatic/Hematologic
- ☐ **None**
- ☐ Anemia
- ☐ Bleeding problems

Psychiatric
- ☐ **None**
- ☐ ADD/ADHD
- ☐ Autism

Other (please list):

Social History— Required by Medicare and most insurance companies.

Does the patient…(dropdown): ☐ None apply

…use tobacco products? No — If so, indicate type/amount/duration:

…drink alcohol? No — If so, indicate type/amount/duration:

…use illegal drugs? No — If so, indicate type/amount/duration:

Have you ever been exposed to or infected with (dropdown): ☐ None apply

Gonorrhea No — HIV No

Hepatitis A, B, or C No — Syphillis No

Patient(parent, if minor): x_____ Date:

Doctor: x_____