WELCOME TO DR. WRIGHT'S OFFICE

Today's Date: ______________

Patient Name:____________________________ M F Birth date:______________ Age:_______Single________Married________________

Address: __________________________City______________ Zip_______ Home #:___________ Driver Lic#_______________________

Employer:_____________________________ Occupation: _________________Work #____________ SS#__________________________

Name of Medical Doctor:___________________________ Last Medical Exam_______________ Last Eye Exam_____________________

Who referred you to our office?____________________________ E-Mail:____________________ Full-time Student__________________

Insurance Information

Name of Insured:_____________________________ Insurance Co. Name____

SS# of Insured: _____________________Birth date of Insured:__________________ Relationship to Patient:_______________________

Medical & Family Health History

Are you allergic to any medication? Yes No If yes, please explain:____

List any medications you are currently taking including aspirin, or over the counter medications:___________________________________

____

Have you ever had and eye infection / injury / surgery?____

Do you wear glasses? Yes / No If yes, how old are your present lenses?____

Do you wear contact lenses? Yes / No If yes, how old are you present lenses? ____

Are you pregnant and/ or nursing Yes / No

Please indicate if you or any family member (living or deceased) have had any of the following conditions:

Blindness: Yes / No____________________________ Cataracts: Yes / No______________________________

Crossed Eyes: Yes / No____________________________ Glaucoma: Yes / No______________________________

Macular Degeneration: Yes / No ____________________________ Retinal Detachment: Yes / No______________________________

Arthritis: Yes / No____________________________ Cancer: Yes / No______________________________

Diabetes: Yes / No____________________________ Heart Disease: Yes / No______________________________

High Blood Pressure: Yes / No ____________________________ Kidney Disease: Yes / No______________________________

Autoimmune Disease: Yes / No____________________________ Thyroid Disease Yes / No______________________________

Lazy Eye: Yes / No____________________________ Other: Yes / No______________________________

Social History

This information is kept strictly confidential, however you may discuss this portion with the doctor if you prefer.

Do you have visual difficulty when driving? Yes / No / I Don't Drive If yes, please describe: ____________________________________

Do you use tobacco products? Yes / No If yes, type, amount, how long? ____

Do you drink alcohol? Yes / No If yes, type, amount, how long? ____

Do you use illegal drugs? Yes / No If yes, type, amount, how long? ____

Have you ever been exposed to or infected with? Gonorrhea_______Hepatitis_______HIV_______Syphilis_______Tuberculosis_______

Please list any hobbies, sports, or activities that are of interest to you ____

Review of Systems

Do you currently, or have you ever had any **chronic** problems in the following areas (please mark yes or no):

YES	NO		YES	NO	
☐	☐	Complete Loss of Vision	☐	☐	Ears / Nose / Throat
☐	☐	Blurred / Distorted Vision	☐	☐	Headaches / Migraines / Seizures
☐	☐	Double Vision	☐	☐	Anxiety / Depression
☐	☐	Flashes / Floaters in Vision	☐	☐	Weight Loss / Gain
☐	☐	Glare / Light sensitivity / Halos	☐	☐	Asthma / Bronchitis / Emphysema
☐	☐	Tired Eyes	☐	☐	Anemia / Bleeding
☐	☐	Redness	☐	☐	Genitals / Kidney / Bladder
☐	☐	Dry / Itching / Burning / Gritty Feeling	☐	☐	Diarrhea / Constipation
☐	☐	Excess Tearing / Watering / Discharge	☐	☐	Thyroid / Other Glands
☐	☐	Eye Pain or Soreness	☐	☐	Lupus / Sjogren's / Rheumatoid
☐	☐	Sties or Eye Infections	☐	☐	Skin
☐	☐	Allergies / Hay Fever	☐	☐	Joint / Muscle Pain

If you answered **YES** to any of the above or have a condition not listed, please explain : ____
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Financial Responsibility / Release of Records / Privacy Notice

Payment for services is due at the time of service. Payment is also required before any materials will be ordered. All insurance co-payments and materials charges (glasses and contact lenses) that exceed your insurance coverage must be paid in full before any materials will be released.

When using vision or health insurance, please check your own benefits manual to review coverage. There are many insurance carriers and we will do all that we can to help you receive your maximum coverage.

I understand that I am financially responsible for all the charges whether my insurance pays or not.

I hereby give authorization for payments of insurance benefits to be made to Christopher M. Wright, O.D., for services rendered.

I hereby authorize the release of my records to any hospital, medical practitioner or insurance company that requests this information.

I have read the above conditions and agree to their content:

____DATE______________________________
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

I HAVE **RECEIVED / REFUSED** (please circle one) A COPY OF DR. WRIGHT'S **JOINT NOTICE OF PRIVACY PRACTICES.**

SIGNATURE____DATE______________________________