THANK YOU FOR CHOOSING An Optical Galleria FOR ALL YOUR EYECARE NEEDS.

Payment is due in full today. A minimum deposit of 50% is required on all glasses or contact lens orders.

PLEASE READ THE HIPAA PRIVACY NOTICE THAT IS PROVIDED UNDER THIS FORM.

PATIENT INFORMATION

NAME ______________________________

Established Patients may initial here if your ***address*** *has not changed.* _______

ADDRESS ______________________________

CITY ____________________ STATE ________ ZIP ________

PHONE Home ____________________ **Cell** ____________________

E-MAIL ______________________________

AGE ______________ **DATE OF BIRTH** ____________________

PATIENT's UNDER 18 *PLEASE PROVIDE THE NAME OF ACCOMPANYING PARENT OR GUARDIAN RESPONSIBLE FOR PAYMENT:*

____

ARE WE SEEING YOU TODAY FOR A : *(Please circle)*

ROUTINE EYE EXAM DIABETIC EYE EXAM MEDICAL EYE PROBLEM

Please provide a brief explanation of the problem you are experiencing:

____

____

When and what time did this problem begin ? ____________________

DATE OF LAST EYE EXAM: _______ *(approx)*

HOW MANY HOURS PER DAY DO YOU SIT IN FRONT OF A COMPUTER? ____________________

FAMILY PHYSICIAN ____________________ Date of last visit? 20____

OCCUPATION ______________________________

HOBBIES ______________________________

HOW DID YOU HEAR ABOUT US? ____________________

Drivers license renewal - Please provide us with your form prior to your exam.

An Optical Galleria, llc, only participates with BCBS and MDIPA Insurance. You MUST have EXTENDED ROUTINE VISION COVERAGE on your plan in order for any insurance to provide payment for routine vision coverage. Medical insurance plans do not cover routine vision care. We are out-of-network providers for Davis Vision, VSP or other independent vision plans. We will gladly complete your out-of-network paperwork for you to submit directly.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I have received and reviewed information regarding the NOTICE OF PRIVACY PRACTICES and am aware of my privacy disclosures.

SIGNATURE ______________________________**DATE** __________

MEDICAL HISTORY

DO YOU HAVE GLASSES? ☐ yes or ☐ no

DO YOU WEAR CONTACTS ? ☐ yes or ☐ no

ARE YOU TAKING ANY MEDICATION(S):

☐ yes or ☐ no *If yes, please list*

____

____

____

____

HAVE YOU HAD CATARACT SURGERY?

☐ yes or ☐ no

HAVE YOU HAD LASIK SURGERY?

☐ yes or ☐ no

HAVE YOU BEEN DIAGNOSED WITH LYME'S DISEASE? ☐ yes or ☐ no *If so, when*?_______

ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

- ☐ EYE STRAIN
- ☐ NEAR VISION BLUR
- ☐ DISTANCE VISION BLUR
- ☐ INTERMEDIATE VISION BLUR
- ☐ DOUBLE VISION
- ☐ HEADACHES
- ☐ SEEING SPOTS/LINES
- ☐ SEEING FLASHES
- ☐ SEEING HALOES

DO YOU SUFFER FROM OR KNOW YOUR FAMILY HISTORY REGARDING THE FOLLOWING?

CATARACTS	☐ SELF	☐ FAMILY
HIGH BLOOD PRESSURE	☐ SELF	☐ FAMILY
SEIZURES	☐ SELF	☐ FAMILY
DIABETES	☐ SELF	☐ FAMILY
HIGH CHOLESTEROL	☐ SELF	☐ FAMILY
MULTIPLE SCLEROSIS	☐ SELF	☐ FAMILY
CARDIAC DISEASE	☐ SELF	☐ FAMILY
SICKLE CELL ANEMIA	☐ SELF	☐ FAMILY
ALLERGIES	☐ SELF	☐ FAMILY
GLAUCOMA	☐ SELF	☐ FAMILY
LAZY EYE	☐ SELF	☐ FAMILY
CROSSED EYE	☐ SELF	☐ FAMILY
COLOR BLINDNESS	☐ SELF	☐ FAMILY
MACULAR DEGENERATION	☐ SELF	☐ FAMILY
RETINAL DETACHMENT	☐ SELF	☐ FAMILY
HEPATITIS	☐ SELF	☐ FAMILY
HIV/AIDS	☐ SELF	☐ FAMILY

OTHER: ______________________________

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