Welcome!

Today's Date _____

Last Name _____ First _____ Middle _____

Name you prefer to be called _____ If under age of 18, responsible party's name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Email _____

Birth Date ____/____/____ Social Security Number ____/____/____ Gender ☐Male ☐Female

Race _____ Ethnicity _____

Employer _____ Occupation _____ Work Phone # _____

Work Address _____ City _____ State _____ Zip _____

Emergency Contact Name _____ Relationship _____ Phone # _____

Vision Insurance Carrier _____ Member ID #or SSN _____
Primary Member Name _____ Relationship _____ Primary Member Birthdate ____/____/____

Health Insurance Carrier _____ Member ID# or SSN _____
Primary Member Name _____ Relationship _____ Primary Member Birthdate ____/____/____

Medicare/Medicaid _____ Member ID #or SSN _____
Primary Member Name _____ Relationship _____ Primary Member Birthdate ____/____/____

Referral Whom may we thank for referring you?

☐VSP List ☐Yelp.com ☐Internet: Which site? _____
☐Live/Work Nearby ☐Shop Nearby ☐Doctor/School Nurse
☐Friend /Relative – their name _____

Payment and Privacy Policy

Insurance Signature on File

Initial: _____ I certify that the information given by me in applying for Insurance payments are true and correct. I request that payment of authorized Insurance benefits be made to Dr Sandra Lee for any services and materials furnished. I authorize any holder of medical information about me to release to HCFA or Insurance agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown. I understand that I am responsible for the balance of fees not paid by insurance.

Initial: _____ I have read and understand the Privacy Policy (HIPAA). I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Dr. Sandra Lee, Optometrist, APC.

_____ _____
Signature on File Date

_____ _____
Signature on File Date

Payment is Due Upon Completion of Exam Today.

*** Please turn this form over & complete side two ***

Medical History

Do you have any allergies to medications? ☐No ☐Yes If yes, explain: _____
Are you currently seeing a physician for any health problems? ☐No ☐Yes
If yes, what? _____
List any medications you take (including birth control, aspirin, or over the counter medications and home remedies):

MEDICATION _____ FOR _____
MEDICATION _____ FOR _____
MEDICATION _____ FOR _____

Are you pregnant and/or nursing? ☐Yes ☐No If yes, how many months pregnant? _____
Have you had LASIK/PRK done? ☐Yes ☐No If yes, when was the procedure done? _____
Are you: ☐Currently wearing contact lenses ☐Have worn contact lenses in the past ☐Interested, but have not worn
Type of contact lenses: ☐Hard ☐Soft ☐Extended Wear How often do you replace lenses? _____
Date of Last Eye Exam _____ Doctor _____

Family History Please note any family history: parents, grandparents (maternal/paternal), siblings, children, extended relatives; living or deceased for the following conditions:

DISEASE/CONDITION	No	Yes	WHO	DISEASE/CONDITION	No	Yes	WHO
Blindness	☐	☐		Arthritis	☐	☐	
Eye/Brain Tumor	☐	☐		Cancer	☐	☐	
Crossed Eyes	☐	☐		Diabetes	☐	☐	
Glaucoma	☐	☐		Heart Disease	☐	☐	
Cataract	☐	☐		High Blood Pressure	☐	☐	
Macular Degeneration	☐	☐		Kidney Disease	☐	☐	
Retinal Detachment/Disease	☐	☐		Lupus	☐	☐	
Eye Growths	☐	☐		Thyroid Disease	☐	☐	
Eye Surgery	☐	☐		High Cholesterol	☐	☐	
Other _____	☐	☐		Other _____	☐	☐	

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐ *Yes*, I would prefer to discuss my Social History with my doctor (Check box)
Do you use tobacco products? ☐No ☐Yes If yes, type/amount: _____
Do you drink alcohol? ☐No ☐Yes If yes, type/amount: _____
Do you use illegal drugs? ☐No ☐Yes If yes, type/amount: _____
Have you ever been exposed to or infected with: ☐ Syphilis ☐Gonorrhea ☐Hepatitis ☐HIV ☐ None

Review of Systems Are you having any problems in the following areas:

	No	Yes		No	Yes
EYES			RESPIRATORY		
Loss of Vision/Side Vision	☐	☐	Asthma	☐	☐
Poor Distance/Near Vision	☐	☐	Chronic Bronchitis	☐	☐
Distorted Vision/Halos	☐	☐	Emphysema	☐	☐
Double Vision	☐	☐	VASCULAR / CARDIOVASCULAR		
Strained / Tired Eyes	☐	☐	Diabetes	☐	☐
Flashes	☐	☐	Heart Pain	☐	☐
Floaters in Vision	☐	☐	High Blood Pressure	☐	☐
Eye Injury	☐	☐	Vascular Disease	☐	☐
Dryness	☐	☐	GASTROINTESTINAL		
Mucous Discharge	☐	☐	Diarrhea/	☐	☐
Redness	☐	☐	Constipation	☐	☐
Sandy or Gritty Feeling	☐	☐	GENITOURINARY		
Itching	☐	☐	Genitals/Kidney/Bladder	☐	☐
Burning	☐	☐	BONES / JOINTS / MUSCLES		
Foreign Body Sensation	☐	☐	Rheumatoid Arthritis	☐	☐
Excess Tearing/Watering	☐	☐	Muscle Pain	☐	☐
Glare / Light Sensitivity	☐	☐	Joint Pain	☐	☐
Eye Pain or Soreness	☐	☐	LYMPHATIC / HEMATOLOGIC		
Chronic Infection of Eye or Lid	☐	☐	Anemia	☐	☐
Sties or Chalazion	☐	☐	Bleeding Problems	☐	☐
ENDOCRINE			ALLERGIC / IMMUNOLOGIC	☐	☐
Thyroid/Other Glands	☐	☐	PSYCHIATRIC	☐	☐
EARS, NOSE, MOUTH, THROAT			CONSTITUTIONAL		
Allergies/Hay Fever	☐	☐	Fever, Weight Loss/Gain	☐	☐
Sinus Congestion	☐	☐	INTEGUMENTARY (Skin)	☐	☐
Runny Nose	☐	☐	NEUROLOGICAL		
Post – Nasal Drip	☐	☐	Headaches/Migraines	☐	☐
Chronic Cough	☐	☐	Migraines	☐	☐
Dry Throat/Mouth	☐	☐	Seizures	☐	☐