Welcome to our office!

Clayton G. Skrzypczak, O.D.
Kathleen M. Leahy, O.D.

Date:_____

Name: (last,middle initial, first):_____ Sex: M F
DOB:_____ Age:_____ Marital Status:_____ SSN:_____
Mailing address:_____ City: _____
State:_____ Zip:_____ Preferred telephone #:_____
Employer:_____ Occupation: _____
Guardian/parent (if under 18): _____DOB: _____
Email: _____ How did you hear about us:_____

Insurance information

Vision: _____ Medical:_____
Subscriber Name (if not self): _____Employer: _____
Subscribers DOB:_____ Last 4 of subscribers SSN:_____

Medical History

Primary care provider:_____Practice name:_____
Preferred Pharmacy: _____

Medications: (if more than listed, we will scan your med list)

Name	Dosage

Are you allergic to any medications? If so, please list_____

Are you currently pregnant? Y / N Are you currently nursing? Y / N
Height: _____ Weight: _____

Ocular (eye) History

Do you wear contacts?: Y / N IF yes, brand:_____Are you interested in contacts: Y / N
Any previous eye surgeries, injuries, or diagnoses?:_____

Ocular (eye) medications: (e.g. AREDS, glaucoma drops, artificial tears)

Medication	Dosage

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Social History

Are you a tobacco user? Y /N — How many cigarettes/packs per day: _____
Do you drink alcohol? Y / N — How many drinks per week?_____
Do you drink caffeine? Y /N — How many cups per day? _____

Pertinent Family History

Please check the box if any direct relative has these medical or eye conditions:

Glaucoma: □ — Hypertension: □
Cataracts: □ — Diabetes: □
Macular Degeneration: □ — Other: □_____

Review of systems

Please check yes or no as these relate to your current health conditions

Allergic/immunologic: Y / N	**Genitourinary: Y / N**
Seasonal allergies: □ / □	STDS: □ / □
Environmental allergies: □ / □	**Hematological/lymph:**
Lupus: □ / □	Anemia: □ / □
Rheumatoid arthritis: □ / □	Leukemia: □ / □
Cardiovascular:	**Integumentary:**
Heart disease: □ / □	Eczema: □ / □
Hypertension: □ / □	Rosacea: □ / □
Cholesterol □ / □	Psoriasis: □ / □
Stroke: □ / □	**Musculoskeletal:**
Constitutional:	Fibromyalgia: □ / □
Weight loss: □ / □	Muscular dystrophy: □ / □
Fatigue: □ / □	Osteoarthritis: □ / □
Fever: □ / □	Ankylosing spondylitis: □ / □
Ear, nose, and throat	**Neurological:**
Ear ache: □ / □	Headaches □ / □
Ringing/tinnitus: □ / □	Multiple Sclerosis: □ / □
Sore throat: □ / □	Epilepsy: □ / □
Runny nose: □ / □	Migraines: □ / □
Endocrine:	Parkinsons: □ / □
Non-Insulin diabetes: □ / □	**Psychological:**
Insulin diabetes: □ / □	Depression: □ / □
Thyroid: □ / □	Anxiety: □ / □
Gastrointestinal:	Schizophrenia: □ / □
Crohns: □ / □	Bipolar disorder: □ / □
Colitis: □ / □	**Respiratory:**
Ulcer: □ / □	Asthma: □ / □
Nausea: □ / □	Bronchitis: □ / □
Vomiting: □ / □	Emphysema: □ / □
Ocular (eyes):	**Other:**
Glaucoma: □ / □	_____
Cataracts: □ / □	_____
Macular degeneration: □ / □	_____
	_____

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EFFECTIVE DATE OF NOTICE: May 1, 2015

NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us. We understand your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. A copy of our privacy policy is available upon request.

Name of family member/friend/etc we may share your protected information with.

Name:_____
Relationship:_____

AUTHORIZATION

I authorize the professional office of my optometrist named above to release health information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/ or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual billed services. I agree to be responsible for payment of all services rendered on my behalf or myself or my dependents.

FINANCIAL RESPONSIBILITY

Patients who have optical/medical/vision insurance are reminded that charges for optometric services rendered by our office are the responsibility of the patient and not their insurance carrier. Insurance is a contract between the patient and the insurance company. Services rendered by your doctor on your behalf are services provided to you personally and as such, are your responsibility. While we accept and participate in several insurance plans, it is the responsibility of the patient to be aware of what level of service they are eligible for under their plan. We will cheerfully assist you in any reasonable way in contacting your carrier and filing insurance claims on your behalf. Payment is due on the day of service for examinations unless we have an authorization from a plan that our office participates with. Optical orders require a deposit of half down when ordered, with the remainder due when dispensed. Please acknowledge your understanding of these policies by signing on the line below.

Signature: _____ Date: _____
Patient (or Parent, if under 18)