Eyes & Optics

DR. ROY A. WILSON
Optometrist

WELCOME TO OUR OFFICE!

Date _____

Mr. /Ms./ Mrs./ Miss/ Dr. _____ (circle one) **MALE/FEMALE**
Last First M.I.

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE _____ **CELL PHONE** _____

SOCIAL SECURITY NO. _____ **BIRTHDATE** _____
Month Date Year

EMAIL ADDRESS _____ **RACE** _____

WHAT IS YOUR OCCUPATION (OR GRADE IN SCHOOL) ? _____

WHO IS YOUR CURRENT EMPLOYER _____

MARITAL STATUS? (circle one) **SINGLE/MARRIED/HEAD OF HOUSEHOLD**

PRIMARY INSURED _____
Last First M.I

ADDRESS (IF DIFFERENT) _____

HOME PHONE _____ **BIRTHDATE** _____

EMPLOYER _____ **SOCIAL SECURITY NO.** _____

VISION CARRIER INSURANCE _____ **ID #** _____

MAJOR MEDICAL INSURANCE CARRIER _____ **ID #** _____ **GROUP #** _____

***** IF YOU ARE A NEW PATIENT TO OUR OFFICE, MAY WE ASK WHO REFERRED YOU TO US SO THAT WE MAY**

THANK THEM? _____

AUTHORIZATION / RESPONSIBILITY AGREEMENT

Payment is expected at the time professional services are rendered. A 50% deposit is required before materials are ordered; balance is due upon delivery of materials.

I have requested Roy A. Wilson, O.D., P.C. to bill my insurance company for the covered services on my behalf. I clearly understand that it is still my responsibility to make sure that the bill is paid in a reasonable time if for any reason any portion of my bill is not paid by my insurance. I further agree to make arrangements for prompt payment of the bill.

In order to process a claim for benefits, I authorize Roy A. Wilson, O.D., P.C. or my insurance company to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under any plan providing benefits or services. I certify that the information provided by me in support of claims is true and correct. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby authorize any insurance company to pay the proceeds of any of my benefits due me directly to Roy A. Wilson, O.D., P.C. A copy of this can be considered as an original for insurance purposes.

Signed_____ Date _____

THANK YOU !

PATIENT HISTORY QUESTIONNAIRE

Acknowledgement of Receipt

I acknowledge that I received a copy of Dr. Roy Wilson's Notice of Privacy Practices

Signature: _____ **Date:** _____

Who is your general physician (Family Doctor) ? _____

Do you have problems with any of these systems? (please circle all that apply) Eyes Y/N

Gastrointestinal	**Y/N**	**Nervous**	**Y/N**	**Mental**	**Y/N**
Ears/ Nose/ Throat	**Y/N**	**Genitourinary**	**Y/N**	**Endocrine (glands)**	**Y/N**
Cardiovascular	**Y/N**	**Musculoskeletal**	**Y/N**	**Blood/ lymph**	**Y/N**
Respiratory	**Y/N**	**Integumentary (skin)**	**Y/N**	**Allergic/ immunologic**	**Y/N**

Please explain: _____

Please answer all that apply:

Diabetes Y/N Type _____ **Date of diagnosis** _____
Allergies Y/N Allergic to what? _____ **What happens?** _____
Medication allergy Y/N What happens? _____ **Headaches Y/N**
Other health problems _____
Current medication(s) _____
Have you had any operations? Y/N Kind? _____ **When?** _____
Do you use cigarettes/tobacco? _____ **Alcohol?** _____ **Other substance(s)?** _____
Name of family doctor _____ **Date of last visit** _____
Date of last tetanus shot _____

FAMILY HISTORY

High blood pressure Y/N Relation _____	**Macular degeneration Y/N**	**Relation** _____
Diabetes Y/N Relation _____	**Retinal detachment Y/N**	**Relation** _____
Glaucoma Y/N Relation _____	**Cataracts Y/N**	**Relation** _____
Other eye condition(s) Y/N What kind? _____		**Relation** _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type _____ **Date** _____
Have you had an eye injury? Y/N Kind _____ **Date** _____
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N
Other eye problems? Y/N What kind? _____
Do you wear glasses? Y/N Contact lenses? Y/N Type _____
Additional information _____

Doctor's initials _____