EYES & OPTICS

Roy A. Wilson O.D. **Lucas J. Wilson O.D.**

PATIENT INTAKE FORM

DATE: _____

Mr./Ms./Mrs./Dr. _____MALE/FEMALE/NON-BINARY

Last First M.I (circle one)

ADDRESS _____

CITY _____STATE_____ZIP CODE _____

CELL PHONE _____ HOME PHONE _____

BIRTHDATE_____SOCIAL SECURITY NO. _____

EMAIL ADDRESS _____ RACE _____

PHARMACY ADDRESS _____PHONE_____

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) _____

PHONE _____ BIRTHDATE _____

EMPLOYER _____ SOCIAL SECURITY NO. _____

VISION INSURANCE CARRIER _____ ID # _____

MEDICAL INSURANCE CARRIER _____ ID # _____ GROUP # _____

WOULD YOU LIKE US TO SHARE YOUR HIPPA INFORMATION WITH ANOTHER PERSON?(Ex. Parents, kids,spouse)

PLEASE LIST THEIR NAME(S) _____

IF YOU ARE A NEW PATIENT TO OUR OFFICE, 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: _____

PERSONAL MEDICAL HISTORY

Do you have problems with any of these systems? (Please circle all that apply)

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**
Headaches	**Y/N**				

Please explain: _____

Please answer all that apply:

High blood pressure Y/N **High Cholesterol Y/N** **Diabetes Y/N Type** _____ **Date of diagnosis** _____

Allergies Y/N Allergic to what? _____ **What happens?** _____

Other health problems _____

Current medication(s) _____

Medication allergy Y/N What medications? _____ **What happens?** _____

Have you had any surgeries/operations? Y/N Kind? _____ **When?** _____

Do you use cigarettes/tobacco? _____ **Alcohol?** _____ **Other substance(s)?** _____

Who is your primary care physician (Family Doctor)? _____

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 _____			**Relation** _____

PERSONAL EYE INFORMATION

Have you had any eye surgery? Y/N Explain: _____ **Date** _____

Have you had an eye injury? Y/N Explain: _____ **Date** _____

Do you have glaucoma? Y/N **Cataracts? Y/N** **Dry eyes? Y/N** **Blurry vision? Y/N**

Other eye problems? Y/N **Explain:** _____

Do you wear glasses? Y/N **Contact lenses? Y/N Daily/2 Week/Monthly Brand Name:** _____
(circle one)

Additional information: _____

Doctor's Initials_____

I acknowledge that I have filled out this form to the best of my knowledge and that any answer to the above questions that I have left blank are considered a "no" or "N/A" response. I also acknowledge that I received a copy of Dr. Wilson's Notice of Privacy Practices.

Signed: _____ Date: _____