History Review Date

Armstrong-Root

Opticians and Optometrists

Name (please print): ______________________________ Birth Date _____/ _____ / ________ M or F ___________
Guardian (if applicable) ____________________________
Billing Address __________________________ City __________________ State _____ Zip Code _____________
Home Phone _________________________ Cell Phone ___________________
Email ____ Occupation _______________________________
Emergency Contact ________________________________ Phone Number __________________________________
Date of Last Eye Exam ____________________ Name of Previous Eye Doctor ________________________________

How would you like to be contacted for future eye exam reminders? E-mail ☐ Phone Call ☐ Text Message ☐ Post Card ☐
How did you hear about us? ____

Personal Medical Information: Do you have problems with any of these systems? If yes please check box.

☐ **MIGRAINES**/Headaches ☐ Nervous System ☐ Mental/Psychiatric
☐ Ear/Nose/Throat ☐ Genitourinary ☐ Endocrine (Glands)
☐ Cardiovascular ☐ Musculoskeletal ☐ Blood/Lymph
☐ Respiratory ☐ Skin ☐ Allergic/Immunologic
☐ Gastrointestinal ☐ Surgeries (what type & when) ____

If you answered yes to any of the above or have a condition not listed please explain:
____
____

Are you in good health? Yes ☐ No ☐

Are you allergic to any medications or other substances? Yes ☐ No ☐ If yes, please list ________________________
____

Primary Medical Dr. ____
Please list any medications you take ____
____

Do you smoke? Yes ☐ No ☐ How much?_______________________________________

Do you drink alcohol? Yes ☐ No ☐ How much? _______________________________________

Do you use other substances? Yes ☐ No ☐

Do you have a history of any of the following?

☐ Dry Eyes ☐ Eye Surgeries ☐ Lazy Eye ☐ Glaucoma ☐ Macular Degeneration
☐ Eye Injuries ☐ Crossed Eyes ☐ Blindness ☐ Cataracts ☐ Retinal Detachment

Any other eye problems? ____

Do you wear glasses? Yes ☐ No ☐ Do You wear contact lenses? Yes ☐ No ☐

Are you interested in laser vision correction? Yes ☐ No ☐

Do you have family history (parents, grandparents, siblings, children) of any of the following?

☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ Glaucoma
☐ Cataracts ☐ Retinal Detachment ☐ Blindness

Other significant medical conditions in your family ____
____

Continued on reverse →

Insurance Patients: We strive to verify benefits and collect copays at the time of service. We cannot guarantee what your insurance will pay. We are happy to bill your insurance company and we will send you a statement of the balance due (if any). Please contact us if you have questions regarding the statement from our office.

Medicare Patients: Medicare Part B does not cover the refraction portion of the exam. There is a $35.00 fee due at the time of service. If you have Part B coverage and you have not met your deductible ($183.00/year), your visit will be applied to your deductible. Some secondary insurances pay the deductible, some do not.

I understand that regardless of my insurance I am ultimately responsible for the balance on my account for services rendered.

Patient or Guardian Signature ____ Date ___________________