Personal Patient Information

Last Name________________________ First_________________ MI_____ Sex ___M ___F

Address_________________________________ City_____________ State_____ Zip_______

Home phone ( )_________ Work phone ( )__________ Cell phone ( )_____________

Date Of Birth__________________________ S.S. # _____-_____-_____

Email_________________________________ Emergency Contact: _______________________

Occupation____________________________________ Employer _________________________

Health Information

Reason for visit: Exam for glasses___ Exam for glasses & contacts___ Eye Infection/Injury___

Last Eye Exam _______________Dr. Name____

How did you hear about us?____

Have you had any surgery or injury to or around your eyes? _____ If yes, explain___________
____

Who is your primary care physician?__________________________Last visit:________________

List any medications you are currently taking: ____

____

Medication Allergies:____

Height:____________ Weight:__________ Are you pregnant? No_____ Yes_____

Health History Please note any family history (parents, siblings, etc living or deceased)

	You	Relative		You	Relative
Glaucoma					
Cataracts			High Blood Pressure		
Eye turn			Low Blood Pressure		
Blindness			High/Low Blood Sugar		
Retinal Disorder			Asthma/Bronchitis		
Color Blindness			Thyroid Disorder		
Macular Degeneration			Cancer/Tumor		
Kidney/ Liver Disorder			Heart/ Vascular Disorder		
Cholesterol			Seasonal Allergies		
G.I. Disorder			Other		
Arthritis			Diabetes		
Fainting/Dizziness			Last A1c/sugar #		

Social History Do you use tobacco products? Y N
If yes, type/amount/how long?____
Are you a __former smoker, __current occasional smoker, __current every day smoker

Do you use alcohol products? Y N

DILATION: It is our goal to provide you a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes which will open the pupil (black spot) and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading (in most cases the distance vision will be unaffected). The side effects last several hours and in some cases may last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may not want to, defer or omit this procedure**.** ***Please indicate your preference below:***

_____ I wish to be dilated today

_____ I do not wish to be dilated and agree to hold Dr. Cremata harmless as a result of my actions

Payment for the doctor is required at time of service

The following forms of payment are accepted: Cash, Check, Mastercard and Visa. If you are paying by check, we require a valid driver's license. Returned checks will be assessed a $25.00 service charge.

Insurance Billing: (your signature below allows us to bill your insurance company)

I request that payment of authorized Vision and/or medical insurance benefits either to me or my behalf be made to Dr. Cremata for any services furnished me by the doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

I also understand that if my insurance company does not provide payment to Dr. Cremata, I will be billed for and agree to pay for said service.

Insurance Information

Do you have vision insurance? Y N If yes, carrier____

Do you have health insurance? Y N If yes, carrier____

Do you have medicare? Y N

Member ID/Policy Number____

Policy holder's Name (if not the patient)____

Policy holder's Date of Birth________________Policy holder's Employer____________________

Relationship to Patient____

PATIENT/GUARDIAN SIGNATURE:_____________________________DATE:______________