



Lee Robertson O.D.

Today's Date _____

Patient Name: _____ Date of Birth ____/____/____ M / F Age: _____

Address: _____
(Street / apt #) (City) (State) (ZIP)

Phone: Home: () - Cell: () - Work: () -

Email: _____ Last 4 digits of primary card holders SSN# _____

Occupation: _____ Employer / School: _____ Payment: Visa / MC Cash Check

Responsible party / parent / guardian (if patient is a child): _____

Responsible party's address / phone: _____
(Street / apt #) (City) (State) (ZIP) (phone number)

What is the main reason for your visit today? _____

When was your last eye exam? _____ Name of Doctor _____

Please list any previous eye injuries or surgeries _____

Today I would like a prescription for: _____ GLASSES _____ CONTACT LENSES _____ BOTH

Do you experience, or have you recently experienced:

- Blurry vision
- Burning
- Tearing
- Grittiness
- Itching
- Poor night vision
- Headaches
- Crossed eyes / eye turn
- Double vision
- Flashes of light
- Floaters / spots
- Problems with glare

Have you or has anyone in your family been diagnosed with:

- | | | |
|----------------------|-------------------------------|---------------------------------------|
| Cataracts | <input type="checkbox"/> Self | <input type="checkbox"/> Family, Who? |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> |
| Lazy Eye (Amblyopia) | <input type="checkbox"/> | <input type="checkbox"/> |
| Iritis / Uveitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Retinal detachment | <input type="checkbox"/> | <input type="checkbox"/> |

Name of your primary care physician: _____

Are you allergic to any medications? YES NO If YES, please list: _____

Please list any prescription or over the counter medications you are currently taking: _____

Are you pregnant or nursing? YES NO Do you smoke? YES NO Do you drink alcohol? YES NO

Do you or does anyone in your immediate family have any of the following health problems? If YES, please specify

- | | | | | | |
|----------------------------|-------------------------------|---------------------------------------|-----------------------------|-------------------------------|---------------------------------------|
| Diabetes | <input type="checkbox"/> Self | <input type="checkbox"/> Family, Who? | Heart Disease/stroke | <input type="checkbox"/> Self | <input type="checkbox"/> Family, Who? |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid | <input type="checkbox"/> | <input type="checkbox"/> |
| High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |

HIPPA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with Elkton Eyecare's Notice of Privacy Policy and have been offered a copy for my records:

Signature: _____ Date: _____

INSURANCE AUTHORIZATION:

I authorize the release of any medical or other information necessary to process this claim AND the payment of medical benefits to Elkton Eyecare, LLC.

Signature: _____ Date: _____