I have read or received a copy of All About Eyes Family Optometry's "Notice of Privacy Practices" with effective date of 3/20/2016
Signed: _____
Date: _____

WELCOME!

All About Eyes Family Optometry
John C. Spaeth, O.D.

Updated:Initial_____ Date_____
Updated:Initial_____ Date_____
Updated:Initial_____ Date_____
Updated:Initial_____ Date_____

Date: _____

Last Name: _____ First Name: _____ Age: _____

Single: ☐ Married ☐ Widowed: ☐ Divorced: ☐ Separated: ☐ Birth Date: _____

Address: _____ City: _____ State _____ Zip: _____

Home phone: _____ Work phone: _____ Cell Phone: _____

Email Address: _____ **Ok to Text: YES / NO**

Social Security Number: _____ Occupation _____

Vision Insurance: _____ Medical Insurance: _____

Name of Person Responsible for Payment: _____ Relationship: _____

Reason for Visit: Vision Analysis: ☐ Contact Lenses: ☐ Laser Surgery: ☐ Other: _____

Former Eye Doctor: _____ Last Date of Exam: _____

Are you interested in Laser Surgery? Yes ☐ No ☐

Do you Drive? Yes ☐ No ☐ If yes, do you have visual difficulty when driving? Yes ☐ No ☐

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and home remedies):

_____

Are you pregnant and/ or nursing? no ☐ yes ☐

Do you wear Glasses? no ☐ yes ☐

Do you wear Contacts? no ☐ yes ☐ Type of Contact Lenses: _____

Are they comfortable? _____

Medical History

DISEASE/CONDITION	NO	YES		NO	YES
Diabetes	☐	☐	Blurred Vision	☐	☐
Diabetic Retinopathy	☐	☐	Loss of Vision	☐	☐
Hypertension	☐	☐	Double Vision	☐	☐
High Cholesterol	☐	☐	Loss of Side Vision	☐	☐
Macular Degeneration	☐	☐	Dryness	☐	☐
Cataract	☐	☐	Excess Tearing/Watering	☐	☐
Glaucoma	☐	☐	Flashes/Floaters in Vision	☐	☐
Cancer	☐	☐	Glare/Light Sensation	☐	☐
High Blood	☐	☐	Distorted Vision/Halos	☐	☐
Headache/Migraine	☐	☐	Crossed Eyes	☐	☐

I hereby authorize this office to inquire about previous health or visual records, and further authorize the release of any information acquired during the course of my treatment or examination. **Payment is expected when services are rendered or ordered.** Payment is required on all lab work before materials can be ordered. **I agree to pay 1.5% per month on any outstanding balance (This is an annual percentage rate of 18%).** Patient assumes all fees necessary to collect outstanding balances. A minimal fee may be charged to complete insurance forms. All returned checks will be subject to a $35.00 returned check charge. **Additional fees for contact lens exam and contact lens fitting will be applied.** I authorize this office to contact me by telephone, mail, or email when it is time for re-examination and practice promotions.

Signature _____ Patient / Parent / Guardian if Minor