Key West Optical

Roger A. Otto, O.D. Dedra Ling, O.D.

Patient Information

Date: _____

Personal

Mr.___ Mrs.___ Ms.___ Dr.___ Sex: ___ Date of Birth: _____ Age: _____

Last Name: _____ First Name: _____ SS#: _____

Address: _____City:_____State:____Zip:_____

Primary#:_____Secondary#:_____Employer/School: _____

Occupation/Grade: _____ **email address: _____**

Preferred Language: English Spanish Creole

Race: American Indian Asian Black Hispanic Hawaiian/Islander White Other

Ethnicity: Hispanic/Latino Native Hawaiian/Pacific Islander Not Hispanic/Latino Other

How Did you Learn About Our Office ?

[ ] Newspaper [ ] Radio [ ] Friend/Relative [ ] Yellow Pages
[ ] Insurance Co. [ ] Walk By [ ] My Physician [ ] Television
[ ] Referred by Another Patient _____

We accept the following forms of payment:
Please indicate below how you intend to pay for your examination

[ ] CASH / CHECK [ ] CREDIT CARD [ ] INSURANCE

****Please note that returned checks will be assessed a $25 service fee****

If you are using insurance, please complete the following and present your card.

[ ] Medicare [ ] Medicaid [ ] BCBS [ ] Aetna [ ] Cigna [ ] TriCare [ ] VCP [ ] VSP [ ] UHC

Name of Insured: _____ Relationship: _____

If other than Patient, Date of Birth: _____SSN:_____ ____Place of Employment: _____

Insurance Co: _____ ID# _____ Group # _____

Supplement: _____ ID# _____ Group # _____

Lifetime Patient Signature: (Your signature is required below which will allow us to bill your insurance company) I request that payment of authorized insurance benefits either to me or on my behalf be made to Key West Optical for any services furnished to me by Dr. Otto/Ling. I authorize any holder of medical information about me, to release 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 Key West Optical, I will be billed for said service.

Lifetime Patient Signature: _____ Date: _____

Health Information

Reason for Visit: [ ] Doctor's Consult/Referral [ ] Laser, Refractive Consult/Referral
[ ] New/Replacement Glasses [ ] New/Replacement Contact Lenses
[ ] Eye Injury
[ ] Eye Health Concerns, explain _____

Last Exam _____ Dr. _____ Last Physical _____ Dr. _____

Have you ever had any injury/surgery to or around your eyes? _____ If yes, please describe _____
_____

Please list any medications you may be taking including eye drops, hormones, and birth control (if you do not know the name of the medication, please list the reason for the medication). _____
_____

Are you allergic to any medications? [ ] No, If yes, please list _____
What is your reaction: [ ] Hives [ ] Dizziness [ ] Other _____

Current: Height _____ **Smoking Status: [ ]** Current [ ] Former [ ] Never

Weight _____ **Social History:** Alcohol Y / N Drugs Y / N

Health History

Please check all that apply:

	You	Blood Relative	Who		You	Blood Relative	Who
Glaucoma	[ ]	[ ]	_____	Diabetes	[ ]	[ ]	_____
Cataracts	[ ]	[ ]	_____	High Blood Pressure	[ ]	[ ]	_____
Lazy Eye	[ ]	[ ]	_____	Low Blood Pressure	[ ]	[ ]	_____
Retinal Disorder	[ ]	[ ]	_____	Heart Disorder	[ ]	[ ]	_____
Blindness	[ ]	[ ]	_____	High Cholesterol	[ ]	[ ]	_____
Macular Degeneration	[ ]	[ ]	_____	Vascular Disorder	[ ]	[ ]	_____
Allergies	[ ]	[ ]	_____	High Blood Sugar	[ ]	[ ]	_____
Color Blindness	[ ]	[ ]	_____	Low Blood Sugar	[ ]	[ ]	_____
Intestinal Disorder	[ ]	[ ]	_____	Thyroid Disorder	[ ]	[ ]	_____
Digestive Disorder	[ ]	[ ]	_____	Cancer/Tumors	[ ]	[ ]	_____
Kidney Disorder	[ ]	[ ]	_____	Asthma/Bronchitis	[ ]	[ ]	_____
Liver Disorder	[ ]	[ ]	_____	HIV/AIDS	[ ]	[ ]	_____
Arthritis	[ ]	[ ]	_____	Pregnant (now)	[ ]		
Fainting/Dizziness	[ ]	[ ]	_____				

If there is any other health concerns/information you would like the doctor to know that is not already listed, please use the space below:

ACKNOWLEDGEMENT of RECEIPT

I, acknowledge that I received a copy of **Roger A. Otto, O.D.,P.A./Dedra Ling, O.D.**
Notice of Privacy Practices (See HIPPA ATTACHED*)

Date:_____

Patient Name:_____ Signature:_____