OMAN EYE CARE

PATIENT INFORMATION

LAST	FIRST	M.I.	NICKNAME

DATE OF BIRTH	SEX:	MARITAL STATUS	SOCIAL SECURITY #

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE #	CELL #	TEXT MESSAGING TO CELL PHONE: YES NO

EMAIL ADDRESS

PATIENT'S EMPLOYER	ADDRESS	WORK #

SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	SPOUSE'S SOCIAL SECURITY #

RESPONSIBLE PARTY INFORMATION (complete ONLY if different from above information.)

LAST	FIRST	M.I.

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE #	CELL PHONE #	DATE OF BIRTH	SOCIAL SECURITY #

EMPLOYER	EMPLOYER ADDRESS	EMPLOYER PHONE #

INSURANCE INFORMATION (Please bring insurance cards to appointment)

VISION INSURANCE	POLICY #	POLICY HOLDER'S SOCIAL SECURITY #

POLICY HOLDER'S NAME	DATE OF BIRTH	RELATIONSHIP TO POLICY HOLDER

MEDICAL INSURANCE	POLICY #	POLICY HOLDER'S SOCIAL SECURITY #

POLICY HOLDER'S NAME	DATE OF BIRTH	RELATIONSHIP TO POLICY HOLDER

How did you learn about Oman Eye Care? (Please check one)

_____ Friend/Family (Who)_____ _____ Medical Doctor

_____ Previous Patient (Who)_____ _____ Yellow Pages _____ Other

OMAN EYE CARE

OMAN OPTOMETRIC EYE CARE, PA

Dr. Heather Oman Dr. Maria Johnson
1607 Westover Terrace
Greensboro, NC 27408

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF PRACTICES

Today I reviewed copy of Oman Eye Care's *Notice of Privacy Practices*.

Name:_____ Date_____

Signature of Patient/Parent/Legal Guardian (Circle One)

_____

Witness

Employee verifies that a copy of legal document authorizing the legal guardian to sign was obtained for the medical record._____ (employee initials)

_____(Check appropriate line)_____refused or _____was unable to sign this statement. However, I gave the above the designated individual a copy of Oman Eye Care's Notice of Privacy Practices, today.

_____ Date:_____

Signature of Employee

RELEASE OF INFORMATION

Name:_____ Date of Birth:_____/_____/_____

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claim information. This information may be released to:

[ ] Spouse_____

[ ] Child/Children_____

[ ] Other_____

[ ] Information is NOT to be released to anyone.

TREATMENT AUTHORIZATION

I authorize you to give me reasonable and proper medical care by today's standards.

Signature of Patient or Authorized Person:_____ Date:_____

Medical History Questionnaire

Name: _____ Date: _____/_____/_____

Birth Date: _____/_____/_____ Last Medical Exam: _____/_____/_____ Last Eye Exam _____/_____/_____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Medical History

Do you have any allergies to medications? □ no □ yes If yes, explain: _____

_____

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

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had:

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury? _____

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

Do you use a computer? □ no □ yes How long per day? _____ Comments _____

Do you wear glasses? □ no □ yes

Do you wear contact lenses? □ no □ interested □ yes If yes, how old is your present pair of lenses?_____

Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Other Are they comfortable? □ no □ yes

Family History

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions?

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other_____	□	□	□	_____

Social History

Do you drive? □ no □ yes If yes, do you have visual difficulty when driving? ? □ no □ yes If yes, please describe:

_____

Do you use tobacco products? □ no □ yes If yes, type/amount/how long?_____

Do you drink alcohol? □ no □ yes If yes, type/amount/how long?_____

Do you use illegal drugs? □ no □ yes If yes, type/amount/how long?_____

Have you ever been exposed to or infected with: □ Gonorrhea □ Syphilis □ HIV □ Hepatitis

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

System	NO	YES	?	EXPLAIN / MEDICATIONS
INTEGUMENTARY (Skin)	☐	☐	☐	_____
NEUROLOGIC				
Headaches	☐	☐	☐	_____
Migraines	☐	☐	☐	_____
Seizures	☐	☐	☐	_____
EYES				
Loss of Vision	☐	☐	☐	_____
Blurred Vision	☐	☐	☐	_____
Distorted Vision / Halos	☐	☐	☐	_____
Loss of Side Vision	☐	☐	☐	_____
Double Vision	☐	☐	☐	_____
Dryness	☐	☐	☐	_____
Mucous Discharge	☐	☐	☐	_____
Redness	☐	☐	☐	_____
Sandy or Gritty Feeling	☐	☐	☐	_____
Itching	☐	☐	☐	_____
Burning	☐	☐	☐	_____
Foreign Body Sensation	☐	☐	☐	_____
Excess Tearing / Watering	☐	☐	☐	_____
Glare / Light Sensitivity	☐	☐	☐	_____
Eye Pain or Soreness	☐	☐	☐	_____
Chronic Infection of Eye or Lid	☐	☐	☐	_____
Styes or Chalazion	☐	☐	☐	_____
Flashes / Floaters in Vision	☐	☐	☐	_____
Tired Eyes	☐	☐	☐	_____
EARS, NOSE, MOUTH, THROAT				
Allergies	☐	☐	☐	_____
Hay Fever	☐	☐	☐	_____
Sinus Congestion	☐	☐	☐	_____
Runny Nose	☐	☐	☐	_____
Post-Nasal Drip	☐	☐	☐	_____
Chronic Cough	☐	☐	☐	_____
Dry Throat / Mouth	☐	☐	☐	_____
RESPIRATORY				
Asthma	☐	☐	☐	_____
Chronic Bronchitis	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____
VASCULAR				
Diabetes	☐	☐	☐	_____
Heart Pain	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Vascular Disease	☐	☐	☐	_____
GASTROINTESTINAL				
Diarrhea	☐	☐	☐	_____
Constipation	☐	☐	☐	_____
GENITOURINARY (genitals / kidney / bladder)	☐	☐	☐	_____
BONES / JOINTS / MUSCLES				
Rheumatoid Arthritis	☐	☐	☐	_____
Muscle Pain	☐	☐	☐	_____
Joint Pain	☐	☐	☐	_____
LYMPHATIC / HEMATOLOGIC				
Anemia	☐	☐	☐	_____
Bleeding Problems	☐	☐	☐	_____
ENDOCRINE (thyroid / other glands)	☐	☐	☐	_____
PSYCHIATRIC	☐	☐	☐	_____

_____ _____

Doctor's Signature Review Date