

THANK YOU FOR CHOOSING **An Optical Galleria** FOR ALL YOUR EYECARE NEEDS.

Payment for exams are due in full today. A minimum deposit of 50% is required on glasses or contact lens orders.

PLEASE READ THE HIPAA PRIVACY NOTICE THAT IS PROVIDED UNDER THIS FORM.

PATIENT INFORMATION

NAME _____

Established Patients may initial here if your address has not changed. _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (H) _____ cell or work _____
(please circle)

E-MAIL _____

AGE _____ DATE OF BIRTH _____

PATIENT'S UNDER 18 MUST PROVIDE THE NAME OF ACCOMPANYING PARENT OR GUARDIAN RESPONSIBLE FOR PAYMENT:

FAMILY PHYSICIAN _____ last visit ____/20____

OCCUPATION _____

HOBBIES _____

HOW DID YOU HEAR ABOUT US? _____

DATE OF LAST EYE EXAM: _____ (If you are a new patient.)

ARE WE SEEING YOU TODAY FOR A ROUTINE EYE EXAM yes

or for a MEDICAL PROBLEM? yes

Please provide a brief explanation of the problem you are experiencing:

When and what time did this problem begin ? _____

An Optical Galleria, llc, only participates with BCBS and MDIPA-State of Maryland Insurance. You MUST have the EXTENDED ROUTINE VISION COVERAGE ON YOUR PLAN. Medical insurance plans do NOT cover routine vision care. If your insurance does not pay, you are responsible for payment in full.

REMINDER- If your license is about expire please provide us with your renewal form at the time of your exam.

I understand that I am financially responsible for all charges whether or not paid by my insurance.

I have also received and reviewed information regarding the NOTICE OF PRIVACY PRACTICES and am aware of my privacy disclosures.

SIGNATURE: _____ DATE _____

MEDICAL HISTORY

DO YOU HAVE GLASSES? yes or no

DO YOU WEAR CONTACTS ? yes or no

HAVE YOU HAD CATARACT SURGERY?

yes or no

HAVE YOU HAD LASIK SURGERY?

yes or no

Have you been diagnosed with Lyme's disease?

yes or no If so, when _____

ARE YOU TAKING ANY MEDICATION(S):

yes or no IF YES, PLEASE LIST

ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

- NEAR VISION BLUR
- DISTANCE VISION BLUR
- INTERMEDIATE VISION BLUR
- DOUBLE VISION
- HEADACHES
- SEEING SPOTS/LINES
- SEEING FLASHES
- SEEING HALOES
- EYE STRAIN

DO YOU SUFFER FROM OR KNOW YOUR FAMILY HISTORY REGARDING ANY OF THE FOLLOWING?

- | | | |
|----------------------|-------------------------------|---------------------------------|
| CATARACTS | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| HIGH BLOOD PRESSURE | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| SEIZURES | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| DIABETES | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| HIGH CHOLESTEROL | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| MULTIPLE SCLEROSIS | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| CARDIAC DISEASE | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| SICKLE CELL ANEMIA | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| ALLERGIES | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| GLAUCOMA | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| LAZY EYE | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| CROSSED EYE | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| COLOR BLINDNESS | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| MACULAR DEGENERATION | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| RETINAL DETACHMENT | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| HEPATITIS | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |
| HIV/AIDS | <input type="checkbox"/> SELF | <input type="checkbox"/> FAMILY |

OTHER: _____