WELCOME TO OUR OFFICE

Dr. Anthony L. Webb
Dr. Alessandra Margain-Salazar
Dr. Michael R. Castro

THERAPEUTIC OPTOMETRISTS

Patient's Name Mr. Mrs. Miss _____

Name of Husband/Wife/Parent _____

Address _____

City _____ Zip _____

Date of Birth (patient) _____

Occupation _____

Student ____ Grade ____ School _____

Employer _____ ☐ Full time ☐ Part time

Home Phone _____ **Work Phone** _____

Cell Phone _____ **E-mail** _____

SSN _____ Driver's License No. _____

In Case of Emergency contact: _____

Nearest relative: _____

Phone: _____

Whom may we thank for referring you to us?

_____

My last exam was _____ years ago.

Doctor _____

☐ Do you play any kind of sports?
☐ Do you wear contact lenses now?
☐ Are you interested in wearing contact lenses? ☐ Refractive Surgery?
Insurance Information:

☐ Medicare # Name of Insured: _____
☐ Medicaid # Date of Birth: _____
☐ Other Ins. # **SSN#** _____
PCP _____
PCP Phone _____

Will your account be paid by:

☐ Check ☐ Cash ☐ MasterCard/VISA/Discover ☐ Ins. _____

Do you wish to be added to our list of regular patients to be notified when it is time again to have your eyes examined? ☐ Yes ☐ No

If your Insurance only pays every two years, do you want an appointment every two years? ☐ Yes ☐ No

Signature: _____

DATE: _____ **Time of Arrival:** _____

COMPREHENSIVE HISTORY
OCULAR REVIEW OF SYSTEMS
Family and Social History

NO	DO YOU HAVE	YES
	Decreased Vision	
	Poor Peripheral Vision	
	Poor Night Vision	
	Poor Color Vision	
	Poor Depth Perception	
	Light Sensitivity	
	Halos around lights	
	Problems with Glare	
	Red Eye	
	Swollen Eye	
	Eye Discomfort	
	Eye Dryness	
	Pressure in or Behind the Eye	
	Discharge	
	Crusting or Red Eyelids	
	Change in Blinking	
	Double Vision	
	Poor Blood Supply to the Back of Your Eyes (AION)	
	Do you drink more than four drinks per week?	
	Do you use drugs or medication that are not prescribed for you?	
	Do you smoke now? (If so, # of packs per day_____)	
	Have you smoked for 1 year or more?	
	Are you concerned that your occupation adversely affects your eyes?	
	What is (was, if retired) your occupation?	
	Specific Visual Requirements?	
	Computer Use?	
	Hobbies	

Patient Name: _____

Med. Rec. Number: _____

Current Medication Hx:

Chronic Illness:

Medication Allergies (including Eye Drops):

NO	HAVE YOU HAD	YES
	EYE HEALTH	
	Vision Therapy	
	Blurred Vision Spells	
	Decreased Vision Spells	
	Fluctuating Vision	
	Eyestrain	
	Eye Surgery (including laser)	
	Eye Injury	
	Serious Eye Infection / Inflammation	
	Headaches	
	Abnormal Pupil	
	Cornea Disease	
	Glaucoma	
	Cataract	
	Eye Disease	
	Eye Tumor	
	Eye Turn	
	MEDICAL HEALTH	
	Learning Difficulty or A.D.D.	
	Diabetes Mellitus	
	High Blood Pressure	
	Heart Disease	
	Lung Disease	
	Neurological Disease	
	Thyroid Disease	
	FAMILY HISTORY OF:	
	Cataracts	
	Glaucoma	
	Diabetes	
	High Blood Pressure	
	Macular Degeneration	
	Blindness (any cause)	
	Other eye Disorders	
	Other Systemic Disorders	

Comments: _____

☐ Additional Comments on Back

Plan: _____

☐ Anthony L. Webb, O.D.
License # 5761TG

☐ Alessandra Margain-Salazar, O.D.
License # 7904T

☐ Michael R. Castro, O.D.
License # 8683T

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this policy.

_____ Copy given to patient

_____ Patient declined copy

_____

Signature of Patient or Patient Representative

_____

Date