PATIENT INFORMATION

Dr. Alan E. Knotek, Optometrist
Dr. Katherine H. Hertzberg, Optometrist
Dr. Mark C. Rafferty, Optometrist

WE KNOW YOU HAD A CHOICE FOR YOUR OPTOMETRIC CARE, THANK YOU FOR CHOOSING OUR OFFICE.

Please bring all your vision and health insurance cards to each appointment.

Please Print.

Patient's **LEGAL** name: Dr./Mr./Mrs./Ms. _____
(Last Name) (First Name) (Middle Initial)

Spouse's **LEGAL** name: Dr./Mr./Mrs./Ms. _____
(Last Name) (First Name) (Middle Initial)

For Minors - Parent's **LEGAL** name: Dr./Mr./Mrs./Ms. _____
(Last Name) (First Name) (Middle Initial)

Address_____City_____State_____Zip_____

Patient's Date of Birth_____ Sex: M F Patient's Social Security #_____

Ethnicity (check one) _____ Hispanic/Latino Origin _____ Non-Hispanic/Latino Origin

Race (check one): ___White ___Black/African Am. ___Am. Indian ___Asian ___Hispanic ___Pacific Islander ___Other

Preferred Spoken Language: _____ Preferred Written Language: _____

Home Phone #_____

Work Phone #_____

Email address_____

Cell Phone #_____

Preferred method of contact regarding appointment reminders and notification of product order availability:

- ☐ Email
- ☐ Personal phone call to home
- ☐ Personal phone call to cell
- ☐ Text to cell
- ☐ Personal phone call to work

Name of previous eye doctor_____

City_____ State_____ Zip_____

Name of your primary care or general family physician_____

City_____ State_____ Zip_____

With your permission, may we correspond with your physician regarding your health/vision? Yes / No

Employer (or school)_____Occupation (or grade)_____

Whom may we thank for referring you to our office?_____

Do you have, or have you had, any of the following? If yes, please check the box.

- ☐ Contact lenses currently
  - ☐ Type of lens_____
- ☐ Eyeglasses for:
  - ☐ Near (reading)
  - ☐ Distance
  - ☐ Computer
  - ☐ Safety glasses
- ☐ Eye injuries Date_____
- ☐ Eye surgeries Date_____
- ☐ I am interested in wearing contact lenses
- ☐ I am interested in LASIK correction

Do you do any of the following? If yes, please check the box.

- ☐ Bike
- ☐ Computer Work Hrs/day?_____
- ☐ Crafts/Sew
- ☐ Fish
- ☐ Golf
- ☐ Racquet Sports
- ☐ Read
- ☐ Read Music
- ☐ Shoot/Hunt
- ☐ Snow Ski
- ☐ Team Sports
- ☐ Woodshop
- ☐ Water Sports

Medical Information

Do you have a health history of any of the following? If yes, please check the box and list any medication/ treatment (prescription or over the counter) you are currently taking.

- ☐ Allergies_____
- ☐ Arthritis_____
- ☐ High Blood Pressure_____
- ☐ Cancer_____
- ☐ Cholesterol_____
- ☐ Diabetes_____
- ☐ Headaches_____
- ☐ Heart Disease_____
- ☐ Insomnia_____
- ☐ Take Oral Contraceptive_____
- ☐ Take Vitamins_____
- ☐ Thyroid Dysfunction _____
- ☐ Other_____
  _____

Do you have an eye history of any of the following? If yes, please check the box.

- ☐ Allergies
- ☐ Cataracts
- ☐ Crossed/Lazy Eye
- ☐ Dry Eyes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Pink Eye / Conjunctivitis
- ☐ Retinal Detachment
- ☐ Eye Trauma
- ☐ Other eye issues

Do you have a family history of any of the following? If yes, please check the box.

- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed/Lazy Eye
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other_____
  _____
  _____

List any medications you are allergic to:

_____

Do you have a social history of smoking? If yes, please check the box.

- ☐ Current Smoker
- ☐ Past Smoker

Insurance/Payment Information

It is your responsibility to know the details of your insurance plans. *Co-pays and deductibles are required at time of service. If possible, we will submit to your insurance company for you.* **FILING A CLAIM IS NOT A GUARANTEE FOR COVERAGE.** *You are fully responsible for any amount not covered by your insurance. If your insurance does not allow for our submission, we will provide you with an itemized bill for you to submit, and therefore, payment in full is required at time of service.*

Who is responsible for payment on your account?

Dr./Mr./Mrs./Ms. _____
(Last Name) (First Name) (Middle Initial)

If different from your address, their Address_____

City_____State_____Zip_____Phone_____

Do you have vision insurance? Yes No Do you have secondary vision insurance? Yes No

Primary Vision Insurance Provider_____ Insurance ID# _____

Subscriber's LEGAL Name_____Relationship to Subscriber _____

Subscriber's Birthdate_____ Subscriber's SS# _____-____-_____ Insurance Group#_____

Do you have health insurance? Yes No Do you have secondary health insurance? Yes No

Primary Health Insurance Provider_____ Insurance ID# _____

Subscriber's LEGAL Name_____Relationship to Subscriber _____

Subscriber's Birthdate_____ Subscriber's SS# _____-____-_____ Insurance Group#_____

Signed_____ Date_____