Snyder Optometry Patient Information and Health Questionnaire

Name:_____ Date of Birth:_____ Gender: M or F

Street Address:_____ City:_____ Zip:_____

Phone #: Home (____) _____ Work (____)_____ Cell (____)_____

Email address:_____ Referred by_____

S.S.#_____ Driver's Lic #_____

Employer_____ Occupation_____

Spouses Name:_____ Date of Birth_____ Phone #_____

Reason for the visit today:_____

Date/Year of last eye exam:_____ How old are current glasses:_____

Personal Health History:

Illness or operation:_____ Year:_____

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Medications you are currently taking including over the counter:

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Drug Allergies: 1)_____ 2)_____ 3)_____

Please check if you have any of the following conditions:

Constitutional: ____Cancer ____ Recent Weight Gain ____ Recent Weight Loss ____ Headaches

Eyes: ___ Cataracts ___Glaucoma ____Burning/Tearing ____Itching ____Redness ___Light sensitivity

Ear/Nose/Mouth/Throat: ___Hearing Problems ___Sinus Problems ___Hay Fever ___Nosebleeds

Cardiovascular: ____High Blood Pressure ____Heart Disease ____Murmur _____Palpitations

Respiratory: ___Asthma ___Emphysema ___Tuberculosis ___COPD

Gastrointestinal: ____Difficulty Swallowing ____Heartburn ____Colitis ____Ulcer

Genitourinary: ____Jaundice ____Hepatitis ____Kidney Stones ____Prostate ____ Venereal Disease

Musculoskeletal: ____ Arthritis ____ Gout

Neurological: ____ Seizures _____Stroke _____ Migraine Headaches

Please Turn page over and continue

Health Questionnaire Continued:

Psychiatric: ____Depression ____Mental Illness

Endocrine: ____ Diabetes (year first diagnosed) _____ _____Thyroid

Hematologic/Lymphatic: _____ Anemia ____ Bruise easily

Allergic/Immunologic: ____ Acne Rosacea ____Lupus

Alcohol: Drinks per week: _____

Smoking: Cigarettes per day:_____ Number of years smoking: _____

Coffee/Soda: Cups per day _____

Patient Name: (print)_____ Date:_____

Parent/Guardian Name: (print)_____

Signature: _____

******Please give all insurance cards to the front desk staff to be copied*******

I have updated and verified the information on my Patient Information/Health Questionaire:

Date: _____ Signature:_____

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Snyder Optometry Inc. **Date:**

Patient's Name:_____

__ Insurance/Managed Care Financial Acknowledgment

I authorize payment for my vision benefits directly to Snyder Optometry Inc. I agree that if my employer, insurance carrier, or plan sponsor denies payment of all or any portion of my claim, I will be financially responsible for all outstanding charges.

Authorization at time of service does not guarantee payment

Signature (patient/guardian) X_____ Relationship to patient: _____

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My doctor has informed me of the need for:

__ **Dilated Fundus Exam** I understand that a condition with the potential for partial or total loss of vision may exist and without dilation it may go undetected. Being advised of this, I decline to have my eyes dilated and I assume the risks of my refusal. Initials_____

Future dilation scheduled for:_____ Initials_____

__ **Glaucoma Eye Pressure Test** I understand that if I have glaucoma and a pressure test is not performed the disease may go undetected with the potential for a partial or total loss of vision. Being advised of this, I decline to have my eye pressure tested and I assume the risks of my refusal. Initials _____

__ **Fundus Photography** I understand that a condition with the potential for partial or total vision loss may go undetected and/or undocumented for future comparison. Being advised of this, I decline to have fundus photography done and I assume the risks of my refusal.
Initials _____

Signature (parent/guardian) X _____ Relationship to patient _____