# WELCOME TO ANDOVER OPTICAL

Name ______________________________ Today's Date ____________

Mailing Address ______________________________

City, State, Zip ______________________________

Date of Birth ____________ Age ________ Sex: M F

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Social Security # **(Insurance Info Only)** ____________

**How did you hear about our office? (please circle)**

Direct Mail Newspaper Internet Community Event

Insurance Friend/Relative (Who?) ____________

Drive by Phone Book: (Which one?) ____________

Email address **(used for recall reminders and special events)** ____________

## Medical History

Do you have any allergies to medications? Yes No Which ____________

Are you pregnant and/or nursing? Yes No

List any medications you are taking (oral contraceptives, aspirin, over the counter medications and home remedies)

Last Physical? Name of Primary Care Physician: ____________

## Visual Needs

Do you wear glasses? Yes No If yes, how old are your current lenses? ________

Do you wear contact lenses? Yes No If yes, how old are your current lenses? ________

Type of contacts: soft rigid extended wear Are they comfortable? Yes No

Are you planning to get new glasses today? Yes No Only if Rx changes

Are you planning to get new contacts today? Yes No Only if Rx changes

Date of last eye exam ____________

***Do You .......***

Work at a computer for long periods of time? Yes No

Have only one pair of glasses? Yes No

Want information on thinner/lighter lenses? Yes No

Spend a lot of time outdoors? Yes No

Ever find a need for prescription sunglasses? Yes No

Have Problems with glare or reflections? Yes No

Does your work require safety glasses? Yes No

Participate in sport activities? Yes No

Want information about ordering contacts on-line? Yes No

Want information about corrective vision surgery? Yes No

## Social History

***This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.***

○ Yes I would prefer to discuss my Social History information with my doctor.

Do you use tobacco products? Yes No

Do you drink alcohol? Yes No

Have you ever been exposed to or infected with HIV? Yes No

**PLEASE COMPLETE INFORMATION ON NEXT PAGE**

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

| | | | |
|---|---|---|---|
| Blindness | Yes | No | Relationship ______________ |
| Glaucoma | Yes | No | Relationship ______________ |
| Macular Degeneration | Yes | No | Relationship ______________ |
| Retinal Detachment/Disease | Yes | No | Relationship ______________ |
| Arthritis | Yes | No | Relationship ______________ |
| Cancer | Yes | No | Relationship ______________ |
| Diabetes | Yes | No | Relationship ______________ |
| Heart Disease | Yes | No | Relationship ______________ |
| High Blood Pressure | Yes | No | Relationship ______________ |
| Thyroid Disease | Yes | No | Relationship ______________ |

## REVIEW OF SYSTEMS

Do you currently have, or have you ever had any problems in the following areas:

### Constitutional

| | | |
|---|---|---|
| Fever, weight loss/gain | Yes | No |

| | | |
|---|---|---|
| **Integumentary (skin)** | Yes | No |

### Neurological

| | | |
|---|---|---|
| Headaches | Yes | No |
| Migraines | Yes | No |
| Seizures | Yes | No |

### Eyes

| | | |
|---|---|---|
| Loss of Vision | Yes | No |
| Blurred Vision | Yes | No |
| Distorted Vision/Halos | Yes | No |
| Loss of Side Vision | Yes | No |
| Double Vision | Yes | No |
| Mucous Discharge | Yes | No |
| Redness | Yes | No |
| Sandy or Gritty Feeling | Yes | No |
| Itching | Yes | No |
| Burning | Yes | No |
| Foreign Body Sensation | Yes | No |
| Excessive Tearing/Watering | Yes | No |
| Glare/Light Sensitivity | Yes | No |
| Eye Pain or Soreness | Yes | No |
| Chronic Infection of Eyelid | Yes | No |
| Styes or Chalazion | Yes | No |
| Flashes/Floaters in Vision | Yes | No |
| Tired Eyes | Yes | No |

### Endocrine

| | | |
|---|---|---|
| Thyroid/Other Glands | Yes | No |
| **Allergic?immunologic** | Yes | No |
| **Psychiatric** | Yes | No |

### Ear, Nose, Throat, Mouth

| | | |
|---|---|---|
| Allergies/Hay Fever | Yes | No |
| Sinus Congestion | Yes | No |
| Runny Nose | Yes | No |
| Post-Nasal Drip | Yes | No |
| Chronic Cough | Yes | No |
| Dry Throat/Mouth | Yes | No |

### Respiratory

| | | |
|---|---|---|
| Asthma | Yes | No |

### Vascular/Cardiovascular

| | | |
|---|---|---|
| Diabetes | Yes | No |
| Heart Pain | Yes | No |
| High Blood Pressure | Yes | No |
| Vascular Disease | Yes | No |

### Gastrointestinal

| | | |
|---|---|---|
| Diarrhea | Yes | No |
| Constipation | Yes | No |

### Genitourinary

| | | |
|---|---|---|
| Genitals/Bladder | Yes | No |
| Kidney | Yes | No |

### Bones/Joints/Muscles

| | | |
|---|---|---|
| Rheumatoid Arthritis | Yes | No |
| Muscle Pain | Yes | No |
| Joint Pain | Yes | No |

### Lymphatic/Hematological

| | | |
|---|---|---|
| Anemia | Yes | No |

We will gladly file insurance for you; however your insurance is your responsibility. ANDOVER OPTICAL CANNOT GUARANTEE PAYMENT BY YOUR INSURANCE CARRIER!

SIGNATURE: ______________________ DATE: ______________

# ANDOVER OPTICAL INC.

13855 Round Lake Blvd. N.W.
Andover, MN 55304
763-421-0141

Are you a New Patient: __________ Previous Patient: ____________

Has any member of your family been seen at our clinic before? **YES** ___ **NO** ___

Do you have VSP? Yes ___ NO ___

<u>Does your insurance cover:</u> Exam: Yes ___ No ___

Eye ware/Contacts: Yes ___ No ___

Insurance Company: ____________________________________________

Insurance I.D. # ____________________________________________

Name of Responsible Party: ____________________ D.O.B. ______________

We will gladly file insurance for you; however your insurance is your responsibility. ANDOVER OPTICAL CANNOT GUARANTEE PAYMENT BY YOUR INSURANCE CARRIER! A finance charge of 1.5% will be assessed on any balance after 90 days.

SIGNATURE: ________________________ DATE: ________________