Would you like a copy of Racine Optical's Notice of Privacy Practices for your records? Yes_____ No______

WELCOME TO OUR OFFICE

Last ______________ First ________________MI ____
Street ________________________________
City _______________ State ________ Zip Code_ _______
Phone number ____________________

Patient's SSN ____________________________
Employer (or School) __________________________
Occupation (or Grade) _________________________
Spouse (or Parent's Name) _______________________
Email Address _______________________________
Patients Date of Birth ____________________________

* INSURANCE SUBSCRIBERS NAME & BIRTH DATE ____

VERY IMPORTANT! NEW PATIENTS ONLY:
Whom may we thank for referring you to our office?
Name of friend or relative ____________________
If not referred, how did you choose our office for your needs?

- ❑ Another Dr.
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Newspaper/Radio/TV
- ❑ Yellow Pages:
- ❑ Web Page: Which Web Site? ________________
- ❑ Other ____________________________

*Major Purpose of Visit?
(Circle) Eyeglasses Contacts Vision & Eye Health

Today's Date _____________

PATIENT MEDICAL HISTORY

Name of Family Physician ____________________________
Town ____________________________________
Date of Last Physical Check-up ______________________
Lasik Surgery ________________________________
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills) ___________________________
____
____
____
____

PATIENT EYE HISTORY

Date of Last Eye Exam ___________________________
By Whom? ____________________________________
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind? ___________________________________
Solutions Used ________________________________
If you currently wear contacts are you satisfied with the comfort and the vision from them? __________
If you wear Bifocals, do the lines or head tilting bother you? ______

Family Medical & Eye History (Check all that apply)

	Your Self	- Immediate Family
Asthma	________	/ ________
Blindness	________	/ ________
Cataracts	________	/ ________
Corneal Abrasion	________	/ ________
Glaucoma	________	/ ________
Lazy eye	________	/ ________
Retinal Detachment	________	/ ________
Diabetes	________	/ ________
Heart Disease	________	/ ________
Macular Degeneration	________	/ ________
Iritis/Uveitis	________	/ ________
Cancer	________	/ ________
High Blood Pressure	________	/ ________
High Cholesterol	________	/ ________
Thyroid Disease	________	/ ________
Kidney Disease	________	/ ________

Do you....... (Check box if your answer is yes)

- ❑..Work at a computer?
- ❑..Think you might benefit from thinner, lighter lenses?
- ❑..Have interest in a "Test Drive" of the latest contact lens design
- ❑..Spend time outdoors? (How much?) ___Hrs/week
- ❑..Have prescription sunglasses?
- ❑..Prefer not to wear your glasses at times?
- ❑..Want information on Laser Vision Correction surgery?
- ❑..Have interest in a non-surgical approach to vision correction?
- ❑..Have children?
- ❑..Have family members in need of eye care?

Do you experience...?

___blurry vision ___flash of light ___sunlight sensitivity
___burning ___floaters ___crossed eye/eye turn
___tearing ___grittiness ___trouble seeing at night
___headaches ___itchiness ___uncomfortable contacts
___double vision ___occasional dryness

PAYMENT POLICY:

Eyewear and Contact lenses –To Start Your Order a **50%** down payment is required on all purchases and Remaining Balance Due at Dispense of Glasses or Contacts.

Professional services—payment in full is expected at the time of service. If you have vision and/or health ins., we will submit a claim for you. The balance on your account will remain your responsibility.

I agree and understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I authorize the release of any information necessary to process an insurance claim.

Signature____ Date_______________