Welcome to

CLASSIC OPTICAL

Confidential Patient Information & Medical History

Name (*Mr, Miss, Mrs, Ms, Rev, Dr)*____ Date ________________
Home Address ____ City ________________________ State ____ Zip____________
Home Phone________________________ Work Phone__________________________ Cell Phone __________________________
Birth Date____________________ Age ______ Social Security Number _______-_____-___________
Email Address (used for electronic recall) ____
Employer _______________________ Occupation _____________________________ Married □ Single □ Divorced □ Widowed □
Medical Ins. __________________ ID ______________________ **Vision** Ins. ___________________ ID ____________________
What made you choose Classic Optical for your eye care needs? ____
____

Do you have any allergies to medicines or substances that you are aware of?____
Please list all medications you are currently taking ____
Have you ever had an injury or operation related to your eyes? If so, please detail ____
Please list any past surgeries or injuries in general ____
Are you pregnant or nursing? ______ If so, how long? _________________________ Are you interested in LASIK? ____________
Do you currently wear: Glasses / Contact Lenses (soft / hard)? What brand contacts do you wear? ___________________________
What solution do you use to clean your contacts? _________________ How often do you replace your lenses? _________________
Do you wear your contacts overnight? ______ Do you currently wear sunglasses? ______ Are they prescription Sunglasses? ______
Do you use: Tobacco products (smoke or smokeless)? ___________ Alcohol?___________ Illicit drugs or substances? _________
How long do you use a computer in an average day? ____________________ Do you drive? ________________________________
Have you had problems regarding glare, scratching, smudges or dirt with any glasses you have had? ___________________________
What are your hobbies? ____

Do you experience, or have any family history of difficulties in any of the following areas?

Please indicate with: "SELF" and/or "FAMILY"

Blurred Vision	____________	Sties	____________	Stroke	____________
Distorted Vision	____________	Flashes	____________	Cancer	____________
Double Vision	____________	Floaters	____________	Thyroid	____________
Headaches	____________	Lazy Eye	____________	Allergies	____________
Eyestrain	____________	Cataracts	____________	Kidney Disease	____________
Dry Eyes	____________	Retinal Detach.	____________	Arthritis	____________
Itchy Eyes	____________	Macular Degen.	____________	Digestion	____________
Excess Tearing	____________	Diabetes	____________	Lupus	____________
Red Eyes	____________	Blood Pressure	____________	Psychiatric	____________
Eye Infection	____________	Heart Disease	____________	Skin problems	____________

Is there any other condition or health history not listed above that you feel we should know about? ____________________________
____

What are your health and visual goals during your visit today? ____
____

Your signature below confirms that the information contained above is true, complete and correct to the best of your knowledge. You authorize CLASSIC OPTICAL ***to provide necessary services, treatment and/or materials as needed for my comprehensive ocular health. I have read, understand, and agree to the above terms of service.***

SIGNATURE____ **Date** ____________________

I have been provided an opportunity to review CLASSIC OPTICAL***'s notice of privacy practices in accordance with HIPAA guidelines.***

Please initial: ______________ Doctor reviewed chart______________ Date _______________________

Q12012