

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 \_\_\_\_\_  
 Email Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Married  Single  Divorced  Widowed   
 Medical Ins. Provider \_\_\_\_\_ ID \_\_\_\_\_ Vision Ins. Provider \_\_\_\_\_ ID \_\_\_\_\_  
 What made you choose Classic Optical for your eye care needs? \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_

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 of contact 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 circle if so, and indicate self and/or family:

Blurred Vision _____	Sties _____	Stroke _____
Distorted Vision _____	Flashes _____	Cancer _____
Double Vision _____	Floater _____	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? \_\_\_\_\_

*Please be advised that it is the sole responsibility of the patient and/or guardian to know and understand their insurance benefits in full before seeking treatment, services, or materials from CLASSIC OPTICAL. Our office is happy to submit a medical and/or vision insurance claim on your behalf for treatment, services, or materials requested from us. We will do all we can to provide sufficient information to your insurance carrier(s) to obtain payment for your eye care treatment and/or materials you decide to order. However, in the event your insurance company or companies refuse payment or issue reduced payment for services or materials for any reason, you agree to make immediate payment for any remaining or outstanding balances. You further agree that a minimum \$30.00 charge may be assessed against your account for any payment made that is reversed or returned for insufficient funds. I have read, understand, and agree to the above terms of service:*

Patient (or guardian): \_\_\_\_\_ Date \_\_\_\_\_

Doctor reviewed: \_\_\_\_\_

I have received CLASSIC OPTICAL's notice of privacy practices and have been provided an opportunity for review. Please initial: \_\_\_\_\_