Welcome to our Office!

Patient Information:

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____

PREFERRED NAME: _____ PREFERRED PRONOUNS: SHE/HER HE/HIS THEY/THEM

HOW DID YOU HEAR ABOUT US? _____

CURRENT GENDER IDENTITY: MALE FEMALE FTM MTF OTHER: (PLEASE SPECIFY) _____ GENDER ASSIGNED AT BIRTH: M OR F

ADDRESS: _____
(Street) (City) (State) (Zip)

EMAIL: _____

(emails are used for appointment reminders, order status and recalls only)

Home: _____ CELL: _____

Work:

NAME OF **PRIMARY CARE PHYSICIAN**: _____DATE OF LAST PHYSICAL: _____

EMPLOYER/SCHOOL:_____OCCUPATION: _____

NAME OF EMERGENCY CONTACT/RELATIONSHIP: _____ Home: _____

Work:

INSURANCE HOLDER (Please circle): SELF/SPOUSE/PARTNER/PARENT

VISION INSURANCE: _____MEDICAL INSURANCE_____

Optomap Retinal Imaging Consent:

In our continued efforts to bring the most advanced technology available to our patients, **Academy Eye Associates** now offers **Optomap** digital retinal imaging as part of your comprehensive eye exam. Dr. Meredith Canterbury recommends that **ALL** patients have the internal health of their eyes thoroughly evaluated every year. This is performed as either a **dilated** retinal exam or the **Optomap** retinal imaging.

PLEASE NOTE: THERE IS AN ADDITIONAL CHARGE OF $39 FOR THE OPTOMAP RETINAL EXAM WHICH IS NOT COVERED BY INSURANCE.

☐ I have read and understand the above, and **agree** to the Optomap Retinal Exam.

☐ I have read and understand the above, and **decline** the Optomap Retinal Exam and will have my eyes **dilated.**

Signature: _____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices:

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Academy Eye Associates at any time to obtain a current copy of these practices.

Signature of patient:_____Date:_____

Parent/Guardian signature (if minor):_____

Medical history on back of form

Patient Medical History Form:

WHAT ARE THE MAIN REASONS FOR TODAY'S APPOINTMENT? (PLEASE CHECK ONE OR MORE)

- ☐ Contact lens discomfort
- ☐ Distance blurred vision
- ☐ Near blurred vision
- ☐ Double vision
- ☐ Dry or burning eyes
- ☐ Eye itching or allergies
- ☐ Red eyes
- ☐ Eye tearing or watering
- ☐ Eye pain or soreness
- ☐ Eye discharge/mucus
- ☐ Frequent eyestrain
- ☐ Frequent headaches
- ☐ Floating spots in vision
- ☐ Seeing flashes of light
- ☐ Sudden loss of vision
- ☐ Unusual light sensitivity
- ☐ Other _____
- ☐ Other _____

ALLERGIES TO MEDICATIONS? ☐ **NONE** If yes, please list: _____

_____

CURRENT MEDICATIONS: ☐ **NONE** (Including prescription, over the counter, natural herbs, vitamins, and birth control):

_____

_____

CHECK ANY **EYE CONDITIONS** THAT APPLY TO YOU: ☐ **NONE**

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Dry Eyes / Allergies
- ☐ Strabismus / Amblyopia
- ☐ Surgery _____
- ☐ Other _____

CHECK ANY **MEDICAL CONDITIONS** THAT APPLY TO YOU: ☐ **NONE**

- ☐ Diabetes Type 1 or 2
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart or Vascular Disease / Stroke
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ Lung Disease / Asthma
- ☐ HIV / AIDS
- ☐ Prostate Disease
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Headaches / Migraines
- ☐ Bipolar Disorder
- ☐ ADHD / ADD
- ☐ Depression
- ☐ Pregnant
- ☐ Colitis / Crohn's
- ☐ Rheumatoid Arthritis / Lupus
- ☐ Arthritis
- ☐ Eczema / Rosacea
- ☐ Sinusitis
- ☐ STD
- ☐ Other _____
- ☐ Other _____

Are you a current smoker? ☐ **Yes** ☐ **No** **If yes, how much do you smoke in a day?** _____

Do you drink alcohol? ☐ **Yes** ☐ **No** **If yes, how much?** _____

CHECK ANY **MEDICAL CONDITIONS** THAT APPLY TO **YOUR BLOOD RELATIVES:** ☐ **NONE**

- ☐ Diabetes Type 1 or 2
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease / Vascular Disease
- ☐ Alzheimer's / Dementia
- ☐ Depression
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Lung Disease / Asthma
- ☐ Cancer
- ☐ Autoimmune disorder
- ☐ Other _____
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cataract
- ☐ Retinal Detachment
- ☐ Strabismus/ Amblyopia
- ☐ Other _____