General Information

Date: _____/_____/_____
Patient Age:_____

Last Name_____ First Name_____ MI_____ DOB:____/____/____

M or F SSN:_____/____/_____ Spouse:_____ DOB:____/____/____

Address:_____ City:_____ State:_____ Zip:_____

Home Ph:( )_____ Work Ph:( )_____ Cell Ph:( )_____

Emergency Contact: _____ Relation:_____ Phone#:( )_____

Employer/School:_____ Occupation/School Grade:_____

Email Address:_____ Sports/Hobbies:_____

Name of Responsible Party:_____

I have read and acknowledge the notice of privacy practices.

Date _____ ***Signature*** _____

I understand that I am responsible for services not covered by Insurance.

_____
signature of responsible party

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type:_____ Replace Schedule:_____

Are you interested in contacts? Yes No

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you taken eye medication? Yes No Why?_____

Have you ever been diagnosed with?

Cataracts: Yes No When were you diagnosed?_____

Glaucoma: Yes No When were you diagnosed?_____

Macular Degeneration: Yes No When were you diagnosed?_____

Please circle and explain any of the following past or present conditions that apply:

Blurred Vision - Distance	Burning Eyes	Floaters or Spots	Headaches
Blurred Vision - Near	Itchy Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Watery Eyes	Poor Color Vision	Light Sensitive

Are you currently pregnant or nursing? Yes No

Notes:

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: ___ **None** ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other: ___ Medications_____	**Endocrine:** ___ **None** ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other: ___ Medications:_____	**Respiratory:** ___ **None** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other: Medications:_____
Constitutional: ___ **None** ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other: ___ Medications:_____	**Genitourinary:** ___ **None** ___ Kidney Disease ___ Urinary Tract Infection ___ STD - Herpetic/Chlamydia ___ Other: ___ Medications:_____	**Psychiatric:** ___ **None** ___ ADHD ___ Depression ___ Schizophrenia ___ Other: ___ Medications:_____
Neurological: ___ **None** ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other: ___ Medications:_____	**Musculoskeletal:** ___ **None** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other: ___ Medications_____	**Immunologic:** ___ **None** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other: ___ Medications:_____
Hematological: ___ **None** ___ Anemia ___ Leukemia ___ Other: ___ Medications:_____	**Gastrointestinal:** ___ **None** ___ Crohn's ___ Colitis ___ Other: ___ Medications_____	**Ear/Nose/Throat:** ___ **None** ___ Hearing Loss ___ Upper Respiratory Infection ___ Other: ___ Medications:_____
Dermatologic: ___ **None** ___ Eczema ___ Rosacea ___ Psoriasis ___ Other: ___ Medications_____	**Allergies** (please list) ___ **None** Drug: Environmental:	**Alcohol Use:** **Y** **N** Amount: **Tobacco Use:** **Y** **N** Amount:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

_____

_____

_____

_____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with:

DISEASE / CONDITION

Blindness:	Yes	No	Who?_____
Cataracts:	Yes	No	Who?_____
Glaucoma:	Yes	No	Who?_____
Crossed Eyes:	Yes	No	Who?_____
Macular Degeneration:	Yes	No	Who?_____
Retinal Detachment:	Yes	No	Who?_____
High Blood Pressure:	Yes	No	Who?_____
Diabetes:	Yes	No	Who?_____
Cancer:	Yes	No	Who?_____
Heart Disease:	Yes	No	Who?_____
Thyroid Disease:	Yes	No	Who?_____

Who referred you to our clinic: Family Friend Yellow Pages Other (List)_____

Reviewed by:

Dr _____ Date_____

Patient Financial Information Sheet

Name of Insured: _____

Name of Patient: _____

Major Medical Insurance Carrier (Not Vision): _____

ID#: _____ **Policy** /Group: _____

Eye Care and Financial Policy:

Our office provides the very best eye care for every patient regardless of circumstances or financial situation. We are contractually obligated to submit claims to your insurance carrier on your behalf. However, if you have NO INSURANCE, are UNDER INSURED or meet the criteria of our Financial Policy you may qualify for a discount. ***The following information is strictly confidential. Please check all that apply:***

[ ] Student
[ ] No insurance
[ ] Social Security only
[ ] Sick spouse
[ ] Unemployed
[ ] Few assets
[ ] Other, describe below

[ ] Dependent on family for support
[ ] Underinsured
[ ] Retired, fixed income
[ ] Large medical expenses
[ ] Bankrupt
[ ] Very low income

_____
_____
_____

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient or parent if minor Date

For Office Use Only – For Office Use Only - For Office Use Only – For Office Use Only

I have met with the above patient and discussed our financial policy. Based on my findings I have made the decision to provide a discount of $_____ or _____% toward the payment of his/her medical services.

_____ _____
Doctor Signature Date

FRISKE OPTOMETRIC CENTER

DR. TAMI C. FRISKE
OPTOMETRIST
1200 E El Dorado Place
Suite G-750
Tucson, Arizona 85712
(520) 747-8583

You may refuse this form

I give my permission to release my Protected Health Information (PHI) to:
(ie; spouse, parents, on-line contacts)

1. Leave a voice message at work or home
2.
3.
4.
5.

I may end this authorization with Friske Optometric Center by written request.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barrier prevented obtaining acknowledgement