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:_________________ Who referred you:____________________

I have received or was offered and declined a 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?___________________________

<u>Please circle and explain any of the following past or present conditions that apply:</u>

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:

*** PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE***

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

FRISKE OPTOMETRIC CENTER

DR. TAMI C FRISKE
DR. KEITH E. VOTENS
OPTOMETRISTS
5720 EAST BROADWAY
TUCSON, ARIZONA 85711
(520) 747-8583

You may refuse to sign 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

Patient Financial Information Sheet

Name of Insured: ____

Name of Patient: ____

Name of Insurance Carrier: ____________________________________

ID#:_______________________________ **Policy #:**___________________________

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