WELCOME TO OUR PRACTICE
DR. MICHAEL L RAFF, OD / BROCKPORT OPTOMETRY, PC

This personal vision and health information will help us give you the most complete eye examination possible. All information is confidential.

PLEASE PRINT TODAY'S DATE:_____

NAME:_____ M/F AGE:_____ DATE OF BIRTH:_____

PARENT/GUARDIAN:_____

HOME/CELL:_____

WORK:_____

EMAIL:_____

_____

OCCUPATION:_____

EMPLOYER:_____

MARITAL STATUS:_____ SPOUSES'S NAME:_____

INSURANCE NAME AND POLICY #:_____

WHO MAY WE THANK FOR REFFERING YOU?_____

WHO IS YOU PRIMARY CARE PHYSICIAN?-

_____

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? ROUTINE Y / N OTHER (PLEASE DESCRIBE):

_____

_____

WHEN WAS YOUR LAST EYE EXAM?_____ NAME OF DOCTOR_____

DESCRIBE ANY PROBLEMS WITH YOUR EYES/VISION_____

AGE OF PRESENT GLASSES_____ABOUT HOW MANY HOURS A DAY ARE YOU ON A COMPUTER?_____

IS THIS EXAM FOR CONTACT LENSES?_____ LAST TIME CONTACTS WORN_____

ARE YOU A SMOKER?_____ IF YES, PACKS PER DAY_____(REQUIRED BE INSURANCE COMPANIES)

HAVE YOU HAD: (please circle)

HEADACHE/MIGRANES	Y/N	DOUBLE VISION	Y/N	COLOR BLINDNESS	Y/N
MULTIPLE SCLEROSIS	Y/N	SUDDEN VISION LOSS	Y/N	EYE INJURY	Y/N
FLASHING LIGHTS	Y/N	FLOATING SPOTS	Y/N	HALOES AROUND LIGHTS	Y/N
LAZY EYE/AMBLYOPIA	Y/N	EYE EXCERCISES	Y/N	EYE SURGERY	Y/N
RETINAL DETACHMENT	Y/N	EYE TURN	Y/N	EYE PAIN	Y/N
EYE PATCH	Y/N	LASIK/ RK	Y/N		

DO YOU OR YOUR FAMILY MEMBERS HAVE: (F : FAMILY)

CATARACTS Y / N/ F BLINDNESS Y / N/ F HIGH BLOOD PRESSURE Y / N/ F

HEART PROBLEMS Y / N/ F DIABETES Y / N/ F ARTHRITIS Y / N/ F

ASTHMA Y / N/ F GLAUCOMA Y / N/F MACULAR DEGENERATION Y / N/ F

COLOR BLINDNESS Y / N/ F CANCER/TUMORS Y / N/F HIGH CHOLESTEROL Y / N/ F

STROKE Y / N/F THYROID PROBLEMS Y / N/F LUPUS/SARCOIDOSIS Y / N/ F

PLEASE LIST OR ALL ATTACH MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER) AND THE REASON YOU ARE TAKING THEM:_____

PLEASE LIST ALL ALLERGIES INCLUDING ALLERGIES TO MEDICINE:_____

_____

_____

I GIVE PERMISSION FOR THE DOCTOR TO USE EYE DROPS WITH THIS CHILD.

X_____

To minimize patient expenses, we request payment for professional services, including HMO co-pays, be made at the time those services are rendered. If frame lenses or contact lenses are ordered, a 50% deposit is required. In the event that BROCKPORT OPTOMETRY pursues me for collection of my financial obligations for services rendered to me, I hereby agree to be responsible for reasonable collection and/or attorney fees and to disbursements incurred by BROCKPORT OPTOMETRY.

_____

_____

SIGNATURE DATE