Name: _____ Today's Date:_____

Do you have any of the following concerns about your eyes? Please circle your answer or add information:

Blurry vision	Y / N	Double vision	Y / N	Loss of vision	Y / N
Discomfort	Y / N	Watering/Discharge	Y / N	Decreased night vision	Y / N
Flashes of Light	Y / N	Glare	Y / N		

Other concerns:_____

Have you been told you have any of the following eye conditions?

Dry Eye	Y / N	Cataract	Y / N	Glaucoma or glauc risk	Y / N
Macular Degeneration	Y / N	Lazy Eye	Y / N	Other:_____	

Do you have a history of any of the following:

Cancer	Y / N	MS	Y / N	Depression	Y / N
Type:_____		Epilepsy	Y / N	Anxiety	Y / N
Fatigue Syndrome	Y / N	Migraines	Y / N	Attention Deficit	Y / N
Developmental Disab.	Y / N	Stroke	Y / N	Other psych	Y / N
Hearing Loss	Y / N	Other neuro	Y / N	List:_____	
Sinus infection	Y / N	List:_____			
Dry Mouth	Y / N				
Other Ear/Nose/Throat	Y / N				
List;_____		Asthma	Y / N	Crohn's Disease	Y / N
		Bronchitis	Y / N	Colitis	Y / N
High Blood Pressure	Y / N	COPD	Y / N	Acid Reflux	Y / N
Cong. Heart Failure	Y / N	Sleep Apnea	Y / N	Other Gastrointestinal	Y / N
Heart Disease	Y / N	Other respiratory	Y / N	List:_____	
Vascular Disease	Y / N	List:_____			
Other cardiovascular	Y / N				
Kidney Disease	Y / N	Osteoarthritis	Y / N	Eczema	Y / N
Prostate Disease	Y / N	Arthritis	Y / N	Rosacea	Y / N
BPH	Y / N	Fibromyalgia	Y / N	Cold Sores	Y / N
Other Genitourinary	Y / N	Osteoporosis	Y / N	Shingles	Y / N
List:_____		Gout	Y / N	Psoriasis	Y / N
		Other musc/skel	Y / N	Other Skin issue	Y / N
Diabetes	Y / N	List:_____		List:_____	
Thyroid disorder	Y / N				
Hormone disorder	Y / N	Anemia	Y / N	Environmental allergy	Y / N
Other Endocrine	Y / N	High cholesterol	Y / N	Rheumatoid arthritis	Y / N
List:_____		Large loss of blood	Y / N	Sjogren's	Y / N
		Other blood disorder	Y / N	Other autoimmune	Y / N
Approx. Height_____ Weight:_____		List:_____		List:_____	

Alcohol Use: none/occasional/moderate/heavy

Are you pregnant or nursing? Y / N

Tobacco Use: Never smoked/Former regular smoker/Former occas. smoker/Current occas. smoker/Current daily smoker

Primary Care Doctor:_____ Medical Allergies Y / N _____

Do you have a family history of these? Please circle Yes or No for Mother (M) Father (F) Sister (S) Brother (B)

Diabetes	Y / N	M F S B	Glaucoma	Y / N	M F S B	High Blood Pressure	Y / N M F S B
Cancer	Y / N	M F S B	Cataracts	Y / N	M F S B	Hyperthyroid	Y / N M F S B
Hypothyroid	Y / N	M F S B	Macular degen	Y / N	M F S B	Other eye problem	_____

Please list current medications:_____

_____

Oneonta Optical
209 Main Street
Oneonta, NY 13820

Patient Information
Name:_____ Date of Birth: _____ Age: _____
Address: _____ City:_____State:_____ Zip:_____
Home Phone: _____ Cell Phone: _____
Occupation: _____ Employer: _____
Driver's Lic.#_____ Work Phone: _____
Ethnicity (please circle one): Hispanic/Latino or Non-Hispanic/Latino Gender: Male/Female
Race: White/Black or African American/Asian/American Indian or Alaskan Native/Native Hawaiian or other Pacific Islander/other Preferred language (if other than English):_____
In case of emergency, contact _____ at phone #_____
Emergency contact relationship to you (please circle): Spouse, Parent, Child, Sig.Other, Friend
Vision Insurance: _____
Medical Insurance: _____

*We are NOT a participating provider with Davis Vision, Eye Med, VSP, Aetna, United Health Care, Cigna, some BCBS (Anthem, others), Medicaid and some others. **If you have any of these plans you will be responsible for the entire bill at the time of service.**

MEDICARE HOLDERS PLEASE READ THIS ADVANCE BENEFICIARY NOTICE:
*We do not accept Medicare assignment. You will need to pay for services and materials in full and we agree to bill Medicare part B for covered services and materials for you to receive payment from them. **Medicare does not cover routine eye examinations. It only covers some types of frames and lenses AFTER cataract surgery**. Your coverage may be different if you have a Medicare HMO.

Authorization for Filing of Insurance
I authorize Oneonta Optical to file insurance claims on my behalf. I understand that all services may not be covered (either partially or in full) and that I am responsible for any unpaid balances in a timely manner. Oneonta Optical does not guarantee the accuracy of benefit information given to us by insurance companies.
Signature: _____ Date: _____

Acknowledgement of Receipt
I have received a copy of Oneonta Optical's Notice of Privacy Practices.
Signature: _____ Date: _____

Authorized Signature for a Minor/Dependent/Other
Print Your Name _____ Relationship to patient:_____
Signature: _____ Date: _____