PAUL A. BLAZE, O.D., F.A.A.O. and Associates

Date _____

Welcome to Our Office

Last _____ First _____ MI_____ Age _____ Birth date ____/____/____

Address _____ City _____ State ____ Zip _____

Phone **Cell** ( ) _____ **Home** ( ) _____ **Work** ( ) _____

Email _____ M / F Single Married Spouse/Parent _____

Employer_____ Occupation _____ **SS #** _____-_____-_____

Nearest Relative _____ Phone ( ) _____

Referred By: _____ **Vision Ins.**_____ **Medical Ins.**_____**PPO/HMO**

Primary Ins. Holder: _____ Primary D.O.B. _____Relationship _____

Hobbies/Sports _____Reason for this visit _____

Eye and Health History

Check all that apply

	YOURSELF	FAMILY
Glaucoma	❑	❑
Diabetes	❑	❑
High Blood Pressure	❑	❑
Retinal Detachment	❑	❑
Macular Degeneration	❑	❑
Cataract	❑	❑
High Cholesterol	❑	❑
Heart Disease	❑	❑
Sudden Loss of Vision	❑	❑
Past Eye Surgeries	❑	❑
Crossed Eyes or Lazy Eye	❑	❑

Please explain_____

_____

Are you taking any medications? Y N

Medications: _____

Prescribed for: _____

Allergies:_____

Do you get headaches? Y N Describe:_____

Have you ever worn Contact Lenses? Y N

Are you interested in the laser correction of your vision? Y N

RECOMMENDED: RETINAL PHOTOGRAPHY/OCT FOR EVALUATION OF EYE AND SYSTEMIC MEDICIAL CONDITIONS- ADDITIONAL FEES APPLY: Y N _____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. By signing below I acknowledge that the Notice of Privacy Practices for this office has been made available to me.

Signature of Patient or Legal Guardian: _____ **Date:**_____

PAYMENT IS EXPECTED AT TIME SERVICES ARE RENDERED.
PLEASE BE AWARE OF OUR CANCELLATION POLICY DUE TO FEES THAT MAY OCCUR.

I understand that I am responsible for all fees. I understand that I may request an additional copy of my charges to submit privately for possible reimbursement from my insurance company. I understand that an approved authorization does not guarantee payment. I authorize release of my information to my insurance company and permit a copy of this authorization to be used in place of the original.

Patient Signature: _____

Updated/initial:_____ **Updated/Initial:**_____

Updated/Initial:_____ **Updated/Initial:**_____