Knotts Optometry Patient Paperwork

Name: ____

Date of Birth: ______________________________

Preferred Phone #: _________________________________

Address: ____

E-mail: ____

Last 4 digits of Social Security #: _____________

Occupation/Grade: ____

Employer/School: ____

Medical Insurance: ____

Vision Insurance: ____

<u>Acknowledgment of Receipt</u>

I acknowledge that I received a copy of Marjorie J Knotts, O.D., Notice of Privacy Practices. (A copy of HIPPA privacy practices will be available for you to have if requested at appointment).

Date: ____________ Patient Name: ______________________ Signature: _______________________

*****May we release your glasses or contact lens prescription with your verbal approval to you or a third party of your choice? Y/N**

*****May we use your name, email, and/or address to send you special office from our office? Y/N**

<u>Insurance Authorization</u>

I request that payment of authorized Insurance benefits for any services furnished to me, be made on my behalf to: Marjorie J Knotts O.D. Inc.

I authorize any holder of medical information about me to release my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

Date: ____________ Patient Name: ____________________ Signature: ________________________

Medical Information

Date of last eye exam: _______________ Dilated? Y/N

Have you had any eye operations? Y/N

Type: ____ Date: _________________

Have you had an eye injury? Y/N

Type: ____ Date: _________________

Do you have blurred vision? Y/N

When: ____

Any other eye problems? Y/N

Explain: ____

Do you wear glasses? Y/N

Contact lenses? Y/N

Type: ____

Height: ______________

Weight: ______________

Are you taking any medications? Y/N

If yes, please list below:

____
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____
____

Do you have any medication allergies? Y/N

If yes, what are you allergic to?

____
____
____

Family Physician: ______________________________________

Physician Phone #: _____________________________________

Pharmacy Name: ______________________________________

Pharmacy Phone #: ________________________________

Personal and Family Medical History							
	Self	**Mother**	**Father**	**Sister**	**Brother**	**Daughter**	**Son**
Anxiety							
Asthma							
Atrial Fibrillation							
Cataracts							
Chronic Kidney Disease							
Chronic Obstructive Pulmonary Disease							
Congestive Heart Failure							
Coronary Artery Disease							
Depression							
Diabetes Mellitus, Type I							
Diabetes Mellitus, Type II							
Diabetes Mellitus, Unspecified							
End Stage Renal Disease							
Glaucoma							
Hyperlipidemia							
Hypertension							
Macular Degeneration							
Retinal Detachment							
Peripheral Vascular Disease							

Please list any other health issues not listed above:

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