Sarah H Appel, OD WELCOME TO OUR OFFICE

Patient Information

Name(Last,First,MI) _____ ***Date of Birth:*** _____

Sex M / F ***SSN:*** _____ ***Marriage Status: S M D W (circle one)***

Today's Date: _____

_____
Street

_____
City, State *Zip Code*

_____
Home *Work* *Cell*

_____
Employer (School) *Occupation (Grade)*

_____
Spouse (Parent Name) *Contact #*

Email:_____
Preferred Method of Communication (Circle One):
Phone Text Email Postage

Reason for today's visit: _____
_____

Who Referred you to our office today?
_____

Any problems with Current Contact lenses or Glasses?
_____
_____
_____

****As a courtesy to others, the office reserves the right to reschedule your appointment if you are more than **15 minutes** late. ****

*******No Show Policy**: As an office policy, no more than 3 "No Shows" will be allowed. After this a patient will no longer be able to be scheduled in this office. Minimum 24 hour notice required for cancellation.****

*****PLEASE COMPLETE ALL INSURANCE INFO*****

_____
*****Vision Insurance***

_____
Subscriber Name

_____
Subscriber SSN *Subscriber Birth Date*

_____
*****Primary Medical Insurance***

_____
Subscriber Name

_____
Subscriber SSN *Subscriber Birth Date*

_____
*****Medicare Supplement/Secondary Medical Insurance***

Patient Acknowledgements:

I, _____, do hereby acknowledge that I am responsible to pay any cost not covered by my insurance company regarding charges accrued for myself, and that any outstanding balances will occur in as interest of 1.5% monthly for charges over 30 days and beyond.

Signature Date

I request that payment of authorized insurance benefits be made either to me or on my behalf to the office of Sarah H Appel, OD for any services furnished to me by any physician associated with the practice. I authorize any holder of medical information about me to release to the insurer with whom I am contracted, any information needed to determine these benefits or the benefits payable for related services.

Signature Date

I acknowledge that I reviewed a copy of Sarah H. Appel O.D., Notice of Privacy Practices. (You may request a copy at the front desk)

Signature: Date:

Patient Medical History

Family Physician: _____ Town:_____
Date of Last Physical:_____

CURRENT MEDICATIONS: List **ALL** medication including dosages. (Including eye drops, vitamins, and birth control. Attach list if needed.

_____
_____
_____

Allergies to medications? ❑ Yes ❑ No

If so, list medications: _____
_____

Have you had any surgeries?	❑ Yes	❑ No
Cigarette/tobacco use?	❑ Yes	❑ No
Alcohol use?	❑ Yes	❑ No
Other substance use?	❑ Yes	❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Diabetes	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Thyroid Condition	❑	❑
History of Stroke	❑	❑
History of Heart Attack	❑	❑
Current Headaches	❑	❑
Migraine Headaches	❑	❑
COPD	❑	❑
Asthma	❑	❑
Acid Reflux	❑	❑
Cancer:_____	❑	❑
ADD/ADHD	❑	❑
Autism	❑	❑
Acne Rosacea	❑	❑
Eczema/Psoriasis	❑	❑
Anxiety	❑	❑
Depression	❑	❑
Urinary Condition:_____	❑	❑
GI Condition:_____	❑	❑
Heart Condition:_____	❑	❑
Kidney Condition:_____	❑	❑
Muscle/Bone:_____	❑	❑
Autoimmune Disease:_____	❑	❑

Patient Eye History

Date of Last Eye Exam: _____
By Whom? _____

Do you currently wear contact lenses?
Type: _____ ❑ Yes ❑ No
Solutions Used: _____

Rate your satisfaction of the clarity and comfort of your contact lenses. (10 being most satisfied)
0 1 2 3 4 5 6 7 8 9 10

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Have you ever experienced, been diagnosed or treated for any of the following conditions?

❑ Blurry Vision	❑ Burning
❑ Cataracts	❑ Corneal Abrasions
❑ Crossed eye/Eye turn	❑ Double Vision
❑ Eye Infections	❑ Eye Injury
❑ Flash of Light	❑ Floaters/Spots
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Iritis/Uveitis
❑ Itchiness	❑ Lazy Eye
❑ Macular Degeneration	❑ Occasional Dryness
❑ Retinal Detachment	❑ Sunlight Sensitivity

❑ Other eye issues: _____

Family medical history (check all that apply)

Cataracts	❑
Diabetes	❑
Glaucoma	❑
Heart Disease	❑
Macular Degeneration	❑

HIPAA Release :

___ I authorize the release of my medical information to the following persons:

Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

_____I **do not** authorize the release of my medical information to **any** person.

_____I authorize release of medical information to any person**.**

Signature:_____Date:_____