WOLF EYE CARE

Patient Information

DATE ____________

Last ____________
First ____________ MI ______
Street ____________
City ____________
State ______ Zip Code ______
Home Phone ____________
Cell Phone ____________
Work Phone ____________
Email ____________
Date of Birth ____________ Age ______
Sex ☐ M ☐ F

Single____ Married____ Divorced____ Widowed____

Patient's SSN XXX-XX- ____________
Employer (Or School) ____________
Spouse (Or Parent's Name) ____________

What is the major purpose of this visit?

____

Any problems with your current contact lenses or glasses?

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

- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Crossed Eye/Eye Turn
- ☐ Eye Infections
- ☐ Flash of Light
- ☐ Glaucoma
- ☐ Headaches
- ☐ Itchiness
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Tearing
- ☐ Uncomfortable Glasses
- ☐ Other eye disorders or eye surgeries
- ☐ Burning
- ☐ Corneal Abrasions
- ☐ Double Vision
- ☐ Eye Injury
- ☐ Floaters/Spots
- ☐ Grittiness
- ☐ Iritis/Uveitis
- ☐ Lazy Eye
- ☐ Occasional Dryness
- ☐ Sunlight Sensetivity
- ☐ Trouble Seeing at Night

Insurance Information

Vision Insurance ____________
Subscriber Name ____________
Subscriber SSN XXX-XX- ____________
Subscriber Birth Date ____________

Primary Medical Insurance ____________
Subscriber Name ____________
Subscriber ID ____________
Subscriber Birth Date ____________

Do you participate in a flex spending account?

☐ Yes ☐ No

How will you settle your account today?

☐ Cash ☐ Check ☐ Credit Card

Medicare Release

I authorize benefits to be paid directly to RW Optometric CenterInc/dba, Dr. Robert Wolf. I understand that I am financially responsible for services and materials that Medicare does not cover. I authorize Dr. Robert Wolf or my insurance company(s) to release any information to process my claims. I authorize the release of any medical information necessary to process my claims and the release of information to my referring or primary care physician. Your signature will serve as your "signature on file" for processing Medicare claims.

Signature ____________

HIPPA Privacy Practice acknowledgement: I have received or was offered and declined a notice of privacy practices

Signature ____________ Date ______

What is your ethnicity? ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Unknown/Not Reported

What is your race? ☐ Native Hawaiian ☐ American Indian ☐ African American ☐ White ☐ Unknown/Not Reported

What is your preferred language?
☐ English ☐ Spanish ☐ Other

How did you hear about us? ☐ Website ☐ Friend

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician ______________________
Town ______________________
Date of last physical check-up ______________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control) **If you have a list, we'll copy it**

Height ____________ Weight ____________

Have you ever been diagnosed or treated for the following health problems?

	Yes	No	Explain
Allergies	☐	☐	________
Arthritis	☐	☐	________
Blood/Lymph	☐	☐	________
Bronchitis	☐	☐	________
Cancer	☐	☐	________
Cholesterol	☐	☐	________
Diabetes	☐	☐	________
Digestive	☐	☐	________
Ears/Nose/Throat	☐	☐	________
Endocrine	☐	☐	________
Eczema/Rashes	☐	☐	________
Fatigue	☐	☐	________
Fevers	☐	☐	________
Genitourinary	☐	☐	________
High Blood Pressure	☐	☐	________
Integumentary (Skin)	☐	☐	________
Kidney	☐	☐	________
Muscle/Bone	☐	☐	________
Neurological	☐	☐	________
Psychological	☐	☐	________
Respiratory	☐	☐	________
Sinus	☐	☐	________
Throat Infections	☐	☐	________
Thyriod	☐	☐	________
Unusual Weight Losses/Gains	☐	☐	________
Allergies to Medications?	☐	☐	________

If so, what medications?

Reaction? ______________________
Date of First Reaction? ______________________

Patient Eye History

Date of last eye exam? ______________________
By whom? ______________________

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No
What kind? ______________________
Solutions used ______________________

If you are 13 years or older, what is your smoking history?
☐ Never ☐ Former ☐ Current ☐ Some Days
☐ Every Day

Do you drink Alcohol? # of drinks a day _____ **a week** _____

Do you ever feel depressed? ______________________

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?
☐ Yes (Please Check Boxes) ☐ No

		Relationship:
Blindness	☐	________
Cataracts	☐	________
Corneal Problems	☐	________
Diabetes	☐	________
Glaucoma	☐	________
Heart Disease	☐	________
Lazy Eye	☐	________
Macular Degeneration	☐	________
Retinal Problems	☐	________

Anything else we should know?