STOKOL + FAGALA
OPTOMETRY PLLC

Mr. / Mrs. / Ms. / Dr.

Last Name ______________________

First ______________________ MI ______

Preferred First Name ______________________

Street Address ______________________

Apartment # __________ City ______________

State __________ Zip Code ______________

Home Phone ______________________

Daytime Phone ______________________

Cell Phone ______________________ Text? Y / N

Email Address ______________________

Birth Date ______________________ Age ______

Social Security # ______________________

Employer ______________________

Occupation ______________________

Marital Status ______________________

Spouse's Name ______________________

Parent/Guardian Name ______________________

Relationship to Patient ______________________

Emergency Contact Name ______________________

Emerg. Contact Phone #: ______________________

Ethnicity ______________________

A service fee will be added for returned checks AND any balance that is turned over for collection.

Our office is able to file certain types of medical insurance, and VSP vision insurance. Please present your card to the front desk at check-in for verification.

We will be happy to provide an itemized receipt should you need to submit your claim to other insurance companies.

What is the main reason for today's visit? ______________________

Are you interested in vision correction surgery (Lasik) or contact lenses? Y / N Which? ______________________

Do you have VSP? Y / N How do you plan on taking care of your charges today? Cash / Credit / HSA / Care Credit

Who may we thank for referring you to our office? ______________________

Family members who are now our patients: ______________________

Recreations & Hobbies? ______________________

By my signature below, I certify to the best of my knowledge all information provided is true and correct.

______________________ Patient Signature (or Legal Guardian)

______________________ Date

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OPTOMETRY PLLC

Patient's Name ________________________ Date ______________

OCULAR HISTORY

Approx. Date of Last Full Exam ______ By Doctor ________________ City ________ State ________

Do You Wear Glasses? Y / N Age of Current Pair? ____ How Many Hours A Day Are You On A Digital Device? __________

Do You Wear Contact Lenses? Y / N What Type? Soft / Rigid Contact Lens Solutions? ____________________

Check If You Have Any Of The Following:

___ Blurred Vision ___ Dry Eyes ___ Red Eyes ___ Double Vision
___ Headaches ___ Itching Or Burning ___ Eye Pain Or Discomfort ___ Floaters Or Flashes
___ Tearing Or Discharge ___ Other – Describe: ________________________________

Check If You Have History Of The Following:

___ Glaucoma ___ Macular Degeneration ___ Eye Injury ___ Lazy Eye ___ Crossed Eyes ___ Retinal Disease

___ Cataracts ___ Eye Surgery – What Type? ________________________ When? ______________

Family History Of Above Conditions:

____

Medical History

Present Medications / Supplements

__________ __________ __________
__________ __________ __________
__________ __________ __________

Medications You Are Allergic To

__________ __________
__________ __________

Check If You Have Any Of The Following:

___ Allergies ___ Breathing Problems ___ Gastric Problems ___ Seizures
___ Asthma ___ High Blood Pressure ___ Neurological Problems ___ Anemia
___ Headaches ___ Thyroid Problems ___ Depression Or Anxiety ___ Dry Mouth
___ Diabetes ___ Vascular Disease ___ HIV ___ Muscle Or Joint Pain

Social History

Do You Drive? Y / N Do You Have Difficulty Driving? Y / N

Do You Use Tobacco or E-Cigarettes? Y / N Former Smoker? Y / N Do You Drink Alcohol? Y / N

Please List Any Unusual Use Of Drugs: ____

______________________________ ______________________

Signature (Or Guardian Signature) Date

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Stokol + Fagala Optometry, PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or was given the opportunity to read Stokol + Fagala Optometry, PLLC Notice of Privacy Practice and agree to continue my care with Stokol + Fagala Optometry, PLLC under said terms.

Please indicate whether you would like a printed copy of our Notice of Privacy Practice by checking one of the options below:

☐ I would like a copy ☐ I do not want a copy

I have read and understand this form. I am signing it voluntarily.

____
Print Name

____________________________________ ______________________
Signature **Date**

If you are signing as a personal representative of the patient, please indicate your relationship:

______________________ ______________________
Representative **Relationship to Patient**

I give permission to release my records to the <u>following people</u>:

Name: ____________________________________ Relationship: ______________________

Name: ____________________________________ Relationship: ______________________