

WELCOME TO OPTICS UNIQUE
DRS. GRAY & RAY
Therapeutic Optometrists
Optometric Glaucoma Specialists

(Please Print)

Today's Date: _____ Date of Last Exam: _____ Age: _____
Title (please circle) Mr. Mrs. Ms. Miss Dr. Other: _____ Sex: Male Female

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ SSN: _____ - _____ - _____ Driver's License: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent): _____

Spouse (or Parent's) Work Phone: _____

Family Members still Living at Home:

Spouse/Parents: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

What is the major purpose of this visit? _____

Are you having any problems with your glasses or contacts? _____

Have you ever worn/ are currently wearing contacts? Yes No

What kind? _____

Solutions used _____ Allergies to any solutions? _____

Are you interested in contacts? Yes No Are you interested in Laser Vision Correction? Yes No

Do you have more than one pair of glasses? Yes No Do you have prescription sunglasses? Yes No

Do you want information on thinner lenses? Yes No

How did you find out about our office? Friend or Relative Who? _____

Another Health Care Practitioner Who? _____ Previous Patient Who? _____

Insurance Provider _____ Yellow Pages Other _____

Please List any Conditions you are being treated for:

Please List Current Medications (Prescription and Over the Counter) and the condition you are taking it for:

Name: _____ For: _____

Name: _____ For: _____

Name: _____ For: _____

Name: _____ For: _____

Please List any Known Drug Allergies:

Name of Family Physician: _____ Name of previous Optometrist:

Please check any conditions which apply to you:

- | | | | | |
|--------------------------------------|--|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular
Degeneration |
| <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Vision Therapy | <input type="checkbox"/> Turned Eye (Strabismus) | <input type="checkbox"/> Other: | |

Please check any conditions present in your family members:

- | | | | |
|--|--|------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Turned Eye (Strabismus) | <input type="checkbox"/> Other: _____ | | |

Are you pregnant or nursing? _____ If pregnant, how far along are you?

Do you smoke? Yes No How much? _____ Do you drink alcohol? Yes No How much?

Insurance Information:

Vision Insurance Company: _____

Name of Insured: _____

Relationship to patient: _____ Birth Date of Insured _____

Insured ID number: _____

Group Number: _____

Insured Employer: _____

We MUST have a copy of your Insurance card to file Medicaid, Medicare, and all other insurances!!!!!!!

How will you settle your account today? Check _____ Cash _____ Credit Card _____

I agree to pay for all services and materials not covered by my insurance company, and I agree to have my claim filed electronically. I have reviewed the information above and it is correct to the best of my knowledge.

Patient or Guardian's signature

Date