Welcome to
MARCIANO FAMILY OPTOMETRIC

PATIENT FORM

My information is the same as my last visit. ____YES (Please print your name, sign the bottom and continue to back)

DEMOGRAPHIC INFORMATION

Last, First, M:

Street Address: | Apt #:

City, State, Zip:

Home Phone: | Day Phone: | Cell Phone:

Email:

Preferred Contact Method: Phone Text Postal

Patient Social Security Number:

Date of Birth: | Male / Female

Employer: | Occupation: | Full Time Part Time

Marital Status: Married Single Divorced Widowed

Preferred Language: English Spanish | Ethnicity: Hispanic/Latino Not Hispanic/Latino

Race: Amer. Indian White Black/African American Hispanic Native Pac. Islander Asian

Emergency Contact: | Whom May We Thank for Your Referral?

INSURANCE INFORMATION

	VISION	PRIMARY MEDICAL	SECONDARY MEDICAL OR VISION
Ins. Co. Name			
Insured's Name			
Identification #			
Group #			
Insured's DOB			
Insured's SS#			
Relation to Insured			

NOTICE OF PRIVACY PRACTICES
I acknowledge that I have read and received a copy of Marciano Family Optometric's Notice of Privacy Practices as required by HIPAA regulations.

Signature: _____ Date: _____

ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage with the fore mentioned insurance and assign directly to Marciano Family Optometric all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all co-pays and/or coinsurance. I also understand that in the event that my insurance does not remit payment, I am responsible for any charges, whether paid or not paid by the insurance. I, hereby, authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of my signature on all insurance submissions.

Signature: _____Relationship to Party_____ Date: _____

PLEASE CONTINUE

EYE HISTORY

Date of Last Eye Exam:

Currently Wear Glasses:

Currently Wear Contacts: How Many Hours a Day:

Reason for Today's Visit:

Have you had any eye surgeries or systemic surgeries since your last visit?

Have you or a family member, experienced, or been treated for, any of the following? Circle all that apply? Please name the family member.

Cataracts	SELF	Family:
Cross Eye	SELF	Family:
Glaucoma	SELF	Family:
LASIK or RK/PRK	SELF	Family:
Lazy Eye	SELF	Family:
Macular Degeneration	SELF	Family:
Retinal Detachment	SELF	Family:

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

Blurry Vision	Near
Blurry Vision	Distance
Burning	
Discharge	
Double Vision	
Dryness	
Excess Tearing / Watering	
Eye Infection	
Eye Pain or Soreness	
Floaters or Spots	
Halos	
Headaches	
Itching	
Light Flashes	
Light Sensitivity	
Redness	
Sandy or Gritty Feeling	

MEDICAL HISTORY

Date of Last Physical Exam:

Primary Care Doctors Name:

Primary Care Doctors Number:

Pharmacy:

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply. Please name the family member.

AIDS / HIV	SELF	Family:
Allergies	SELF	Family:
Arthritis	SELF	Family:
Asthma	SELF	Family:
Blood / Lymph Disorder	SELF	Family:
Cancer	SELF	Family:
Diabetes	SELF	Family:
Ears, Nose, Throat Conditions	SELF	Family:
Gastrointestinal Conditions	SELF	Family:
Heart Disease	SELF	Family:
High Blood Pressure	SELF	Family:
High Cholesterol	SELF	Family:
Kidney Disease	SELF	Family:
Lupus	SELF	Family:
Neurological Conditions	SELF	Family:
Psychiatric Disorder	SELF	Family:
Seizures	SELF	Family:
Skin Conditions	SELF	Family:
Stroke	SELF	Family:
Thyroid Dysfunction	SELF	Family:

Current Medications:

Are you allergic to any medications?

Hobbies:	Sports:
Are you Pregnant or Nursing? :	
Do You Smoke?	How Often:
Do You Drink?	How Often: