WELCOME TO OUR OFFICE!

(IN OFFICE USE ONLY)
SCANNED: ☐ ESCRIPT: ☐
INSURANCE: ______________ RV: ☐

☐ MR. ☐ MRS. ☐ MS. ☐ DR.

REFERRED BY: ______________

FULL NAME: ______________

PREFERRED NAME: ______________

ADDRESS: ______________

BIRTH DATE: ____/____/____

CITY/STATE/ZIP: ______________

SOCIAL(SSN): ____/____/____

EMAIL ADDRESS: ______________
(NOTE: AN EMAIL ADDRESS IS REQUIRED IN ORDER FOR YOU TO GAIN ACCESS TO OUR OFFICE'S PATIENT PORTAL)

CELL PHONE: ______________

SCHOOL/GRADE: ______________

HOME PHONE: ______________

EMPLOYER/OCCUPATION: ______________

WORK PHONE: ______________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

PREFERRED METHOD OF CONTACT: ☐ TEXT ☐ CALL ☐ EMAIL

RACE/ETHNICITY:
☐ AMERICAN INDIAN/ALASKA NATIVE
☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER
☐ HISPANIC OR LATINO
☐ WHITE OR CAUCASIAN
☐ BLACK/AFRICAN AMERICAN
☐ PREFER NOT TO ANSWER
☐ ASIAN
☐ OTHER

PRIMARY CARE PROVIDER/CLINIC NAME: ______________

PREFERRED PHARMACY: ______________

ALLERGIES: ☐ NO KNOWN DRUG ALLERGIES ☐ YES (PLEASE LIST) ______________

MEDICATIONS: ☐ NONE ☐ YES (PLEASE LIST ALL CURRENT PRESCRIPTIONS, ORAL CONTRACEPTIVES, AND OVER THE COUNTER MEDICATIONS INCLUDING ASPIRIN)

SOCIAL HEALTH HISTORY

TOBACCO USE: ☐ CURRENT ☐ OCCASIONAL ☐ FORMER ☐ NEVER

PREGNANT/NURSING MOTHER: ☐ YES ☐ NO

SPECIAL EYEWEAR NEEDS

☐ **COMPUTER** (SPECIAL PRESCRIPTIONS, ANTI-GLARE COATING)
☐ **SPORTS/HOBBIES** (SWIMMING GOGGLES, SPORTS GOGGLES, ETC)
☐ **OCCUPATIONAL** (MECHANICS,PLUMBERS,PILOTS)
☐ **SAFETY** (EMPLOYER REQUIRED,GARDENING,WOODWORKING,WELDING)

PERMISSION TO RELEASE HEALTH INFORMATION AND ACCOUNT RESPONSIBILITY

PLEASE LIST ANY FAMILY MEMBERS/FRIENDS THAT YOU WOULD LIKE TO PERMIT ACCESS TO YOUR PROTECTED HEALTH INFORMATION. DUE TO THE HIPAA PRIVACY POLICY, WE CAN **ONLY** RELEASE YOUR INFORMATION TO WHOMEVER IS LISTED.

PERMISSION TO RELEASE HEALTH INFORMATION TO: ______________

IF PATIENT IS **UNDER 18 YEARS OLD**, PLEASE COMPLETE THE FOLLOWING SECTION. THIS PERSON WILL BE FINANCIALLY RESPONSIBLE FOR THE PATIENT'S ACCOUNT.

RESPONSIBLE PARTY NAME: ______________

RESPONSIBLE PARTY DATE OF BIRTH: ____/____/____

RELATIONSHIP TO PATIENT: ______________

RESPONSIBLE PARTY PHONE NUMBER: ______________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED AND AGREE TO THE ***NOTICE OF PRIVACY PRACTICES*** FROM COX EYE CARE.

SIGNATURE: ______________

RELATIONSHIP TO PATIENT: ______________
(IF UNDER 18, MUST BE LEGAL PARENT OR GUARDIAN)

DATE: ____/____/____

TURN OVER TO COMPLETE FORM ➡

CURRENT EYE HEALTH AND OCULAR HISTORY

(CHECK IF YES, CHOOSE ALL THAT APPLY)

CURRENTLY WEARING: ☐ GLASSES ☐ CONTACT LENSES

INTERESTED IN CONTACT LENSES: ☐ YES ☐ NO ☐ MAYBE

DO YOU EXPERIENCE ANY OF THE FOLLOWING?
(INCLUDE SYMPTOMS THAT OCCUR WHILE USING GLASSES OR CONTACTS, IF ANY)

- ☐ BLURRING AT DISTANCE
- ☐ BLURRING AT NEAR
- ☐ LOSS OF SIDE VISION
- ☐ NIGHT VISION PROBLEMS
- ☐ DOUBLE VISION
- ☐ EYE DISCOMFORT OR PAIN
- ☐ REDNESS
- ☐ SANDY OR GRITTY FEELING
- ☐ ITCHING
- ☐ BURNING
- ☐ MUCUS OR MATTERING
- ☐ EXCESSIVE WATERING
- ☐ SPOTS FLOATING
- ☐ FLASHES OF LIGHT
- ☐ DRYNESS
- ☐ LIGHT SENSITIVITY

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

- ☐ CATARACTS
- ☐ CROSSED EYES
- ☐ DRY EYE
- ☐ EYE INFECTION
- ☐ EYE INJURY
- ☐ GLAUCOMA
- ☐ MACULAR DEGENERATION
- ☐ LAZY EYE/AMBLYOPIA
- ☐ RETINAL DETACHMENT
- ☐ RETINAL DISEASE

FAMILY HEALTH HISTORY

(CHECK IF YES, CHOOSE ALL THAT APPLY)

HAVE ANY FAMILY MEMBERS (PARENTS, GRANDPARENTS, SIBLINGS, AND CHILDREN) **BEEN DIAGNOSED WITH:**

	RELATIONSHIP TO PATIENT:
☐ GLAUCOMA	
☐ CATARACTS	
☐ MACULAR DEGENERATION	
☐ CROSSED EYES/LAZY EYE	
☐ RETINAL DAMAGE/DISEASE	
☐ HYPERTENSION	
☐ DIABETES	
☐ ARTHRITIS	
☐ CANCER	
☐ THYROID DISEASE	
☐ HEART DISEASE	

REVIEW OF SYMPTOMS

(CHECK IF YES, CHOOSE ALL THAT APPLY)

ALLERGIC/IMMUNOLOGIC:
- ☐ ENVIRONMENTAL ALLERGY
- ☐ RHEUMATOID ARTHRITIS
- ☐ LUPUS

MUSCULOSKELETAL:
- ☐ FIBROMYALGIA
- ☐ MUSCULAR DYSTROPHY
- ☐ ARTHRITIS

CARDIOVASCULAR/CARDIAC:
- ☐ HEART DISEASE
- ☐ HYPERTENSION
- ☐ STROKE
- ☐ VASCULAR DISEASE

GASTROINTESTINAL:
- ☐ CROHN'S DISEASE/IBS
- ☐ COLITIS
- ☐ ULCER

NEUROLOGICAL:
- ☐ MIGRAINES
- ☐ MULTIPLE SCLEROSIS
- ☐ EPILEPSY
- ☐ ALZHEIMER'S
- ☐ PARKINSON'S

CONSTITUTIONAL:
- ☐ FATIGUE
- ☐ DEVELOPMENTAL DISABILITY

GENITOURINARY:
- ☐ STD, VIRAL HERPETIC, CHLAMYDIA
- ☐ KIDNEY DISEASE
- ☐ OVARIAN/UTERINE CANCER
- ☐ PROSTATE CANCER

PSYCHIATRIC:
- ☐ DEPRESSION
- ☐ PANIC DISORDER
- ☐ SCHIZOPHRENIA

EAR, NOSE, MOUTH, AND THROAT:
- ☐ RINGING/TINITIS
- ☐ DRY THROAT/MOUTH OR CHRONIC COUGH

HEMATOLOGIC/LYMPHATIC:
- ☐ ANEMIA
- ☐ BLEEDING DISORDER
- ☐ LEUKEMIA

RESPIRATORY:
- ☐ EMPHYSEMA
- ☐ ASTHMA

ENDOCRINE:
- ☐ THYROID DYSFUNCTION
- ☐ NON-INSULIN DEPENDENT (II) DIABETES
- ☐ INSULIN DEPENDENT (I) DIABETES

INTEGUMENTARY:
- ☐ ECZEMA
- ☐ ROSACEA
- ☐ PSORIASIS
- ☐ SKIN CANCER

OTHER: ______________________________