BLACKSTONE OPTOMETRY
A MEMBER OF Vision Source™

****Must be completed and received prior to appointment****

Appointment Date_____

Referred By walk-in yelp facebook angie's list insurance directory blackstoneoptometry.com community guide maphawk mailing person doctor optical

Patient Contact Information

Title_____ Last Name_____First Name_____Middle Initial_____
Address_____City_____State_____Zip Code_____
Birth Date_____Gender_____SS#_____
Mobile Phone_____Alternate Phone_____ home work
Email Address_____

Relationships

Guarantor of_____Guaranteed by_____
Other family members_____

Insurance

Vision Plan_____ID Number_____Relation to Insured_____
Medical Insurance Plan_____Policy/Group #_____
Primary Physician_____Phone_____
Employer_____Phone_____

Interested In (select all that apply) Exam Glasses Contacts Sunglasses Refractive Surgery

Main Reason for Visit (select one) Blurred Vision Burning Dry Eye Diabetic Foreign Body Flashes/Floaters Headache Infection Irritation Itching Night Vision Pain Redness Eyestrain Trauma Watery Eye Other

Describe Main Reason for Visit (select all that apply)

Location	Quality	Severity	Duration	Timing	Context	Modifying Factors	Associated Signs
Right Eye	Itch	Mild	Minutes	Morning	At Work	Rx Medication	Redness
Left Eye	Burn	Moderate	Hours	Afternoon	Driving	OTC Medication	Pain
Distance	Blur	Severe	Days	Evening	Reading	Glasses	Watering
Near	Sharp Pain		Weeks	Constant	School	Contacts	Blur
Intermediate	Dull Pain		Months	Winter		Cold Compress	Swelling
Upper Lid	Aching Pain		Years	Spring		Bright Lights/Sun	Double Vision
Lower Lid			Intermittant	Summer		Wind	Reduced Use
Globe				Fall		Stop Activity	Headache
Cheek						Rest	Fatigue
Brow							

Other Description or Reasons for Visit

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Current Medications Name_____For_____
Name_____For_____
Name_____For_____
Name_____For_____
Name_____For_____
Name_____For_____
Name_____For_____
Name_____For_____

Ocular & Medical History

Self Glaucoma Cataracts Macular Degeneration Surgery Other
Hypertension Diabetes Allergies Other(s)

Family Glaucoma Cataracts Macular Degeneration Other
Hypertension Diabetes Other

Visual Needs Occupation/Year in School_____Hobbies_____
Special Visual Needs/Demands_____

Contact Lens History (if applicable) Brand/Name_____Base Curve_____
Where last purchased_____ Prescription Right_____
Prescription Left_____

How long will your current supply last_____
How often worn_____Hours worn per day_____
How often slept in_____How often replaced_____
Which clearning solution_____
How would you like them improved

Are you planning on new glasses today? Yes No Only if there is a change

HIPPA Privacy Statement
At Blackstone Optometry, we value our patients' right to privacy. Your personal medical information will not be shared without your approval. Your signature below acknowledges that you have been made aware of your rights to confidentiality. (www.hhs.gov/ocr/privacy/hipaa/understanding/consumers)

Signature of Responsible Party_____Date_____

Financial Resposibility Statement
I understand that an insurance authorization does not guarantee payment by my insurance carrier. And if payment is not received, I will be responsible for full payment for services performed, and materials or products received.

Signature of Responsible Party_____Date_____