Kraig J. Abe, O.D., F.A.A.O.

WE WELCOME YOU BACK TO OUR OFFICE !

It is always a pleasure to see you and care for your eye care needs.

PATIENT INFORMATION (Please Print)

Last Name | First Name | Initial | Date of birth | Age

Home Address | City / State / Zip Code | Home phone ( )

Occupation | Employer | Work phone ( )

Spouse's name | Children's name(s) / age | Patient Status ☐ Single ☐ Married ☐ Student ☐ Other

Email address (May we contact you by email ? ☐ Y ☐ N) | Signature | Today's Date

PATIENT HISTORY (Please answer to the best of your knowledge)

1. How old are your current SPECTACLES: _____ How old are your current CONTACT LENSES: R _____ L _____
2. Date of last eye examination (if not at this office):_____
3. **What is the *MAIN REASON* for today's visit ?**_____
4. Name / location of your **primary physician**:_____ date of last **physical** exam:_____
5. Do you or any blood relatives have (please check box and state **who**)?

☐ retinal disease	**who:**_____	☐ high blood pressure	**who:**_____	☐ tuberculosis	**who:**_____
☐ cataracts	**who:**_____	☐ thyroid problems	**who:**_____	☐ hepatitis	**who:**_____
☐ glaucoma	**who:**_____	☐ heart condition	**who:**_____	☐ cancer	**who:**_____
☐ diabetes	**who:**_____	☐ high cholesterol	**who:**_____	☐ other	**who:**_____

6. **Females**: Are you ☐ pregnant or ☐ nursing ? ☐ No ☐ Yes
7. Are you being treated for any medical condition or taking medications ? ☐ No ☐ Yes
   Please list condition and medication: _____
8. Do you have any allergies or are you allergic to any medications ? ☐ No ☐ Yes
   Please List:_____
9. Do you or have you ever had any eye disease, eye infection, injury, or surgery ? ☐ No ☐ Yes
   If yes, please explain:_____
10. Do you smoke ? ☐ Yes ☐ No Alcohol consumption: ☐ none ☐ occasional ☐ often Recreational drug use: ☐ No ☐ Yes
11. Do you experience while wearing your glasses or contact lenses ?
    ☐ eyestrain ☐ tearing ☐ eye pain ☐ double vision ☐ trouble with night vision ☐ driving at night
    ☐ dry ☐ burning ☐ itchy eyes ☐ blurred vision ☐ unusual sensitivity to bright lights
    ☐ spots / floaters ☐ flashes of light ☐ frequent or severe headaches ☐ other_____
12. Have you ever been prescribed eye exercises ? ☐ No ☐ Yes
13. Special visual demands (work, hobbies, or activities) _____
14. Are you interested in contact lenses ? ☐ new ☐ color ☐ bifocal / multifocal ☐ **nearsightedness reducing** ☐ No ☐ Yes
15. Are you interested in laser vision correction surgery ? ☐ No ☐ Yes

COMPUTER USERS If you work on a computer, please answer the following:

16. Hours per day:_____ Size of computer monitor(s):_____(inches) Distance from computer screen:_____(inches)
17. Are you experiencing: ☐ eyestrain ☐ blurred vision ☐ headaches while using the computer ? ☐ No ☐ Yes

CONTACT LENSES If you wear contact lenses, please answer the following:

18. Days per week worn: _____ Hours per day: _____ Brand / Name of contacts:_____
19. Type of contacts: ☐ Hard ☐ Oxygen Permeable (RGP) ☐ Soft ☐ Disposable ☐ Astigmatism ☐ Bifocal ☐ Monovision
20. Method of wear: ☐ Daily wear ☐ Flexible wear ☐ Extended wear (overnight) When contacts were last worn:_____
21. Care System: ☐ Heat ☐ Chemical Enzyme use : ☐ Yes ☐ No Name of solution:_____
22. Are you **SATISFIED** with your current brand / type of contact lenses ? ☐ No ☐ Yes

Voluntary Consent Form

Kraig J. Abe, O.D., F.A.A.O.
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Consent to use or disclose health information for treatment, payment and health care operations.

Patient Name: _____ Phone:_____

Patient Address: _____

SIGNING THIS DOCUMENT SIGNIFIES THAT YOU HAVE VIEWED OR RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

We have a comprehensive ***Notice of Privacy Practices*** that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this ***Consent Form***. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name