Today's Date: ____________________ Married/ Divorced/ Single/ Widow(er)/ Dom Partner
Title: Dr. / Mr. / Mrs. / Ms.
Full Name: ____________________ Nickname: ____________ Date of Birth: __________
Home Address: ____________________ Sex: M / F
City/State/zip: ____________________ Social Security Number: ____________
Home Phone: ____________________ Employer (or School): ____________
Cell Phone: ____________________ Occupation (or Grade): ____________
Email: ____________________ Height: ____ft ____in Weight: ______lbs

Name of Insurance Company: Medical ____________ ID# ____________ Vision ____________

I authorize the payment of any eye care and/or medical benefits indicated above to my Doctor of Optometry. I understand that I may have co-payments and overages (costs not paid for by the eye care and/or medical plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: ____________________ Date: ____________

MEDICAL/ OCULAR HISTORY

Please list **anything** you are allergic to: ____________________

Please list **any** medical conditions: ____________________

Please list **any** medications you are currently taking (including eye drops): ____________________

____

Name of Primary Care Physician ____________________ Date of last visit: ____________

SOCIAL HISTORY

Do you use tobacco products? Y / N Drink alcohol? Y / N Use illegal drugs? Y / N

What is your birth order? 1st child 2nd child 3rd child 4th child

Have you ever been exposed to, or infected with: Gonorrhea Hepatitis HIV Syphilis Chlamydia

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

Blindness: Y / N ____________ Diabetes: Y /N ____________
Cataract: Y / N ____________ Heart Disease: Y/ N ____________
Crossed eyes: Y /N ____________ High Blood Pressure: Y / N ____________
Glaucoma: Y / N ____________ Cancer Y / N ____________
Macular Degeneration: Y / N ____________ Lupus: Y / N ____________
Retinal Detachment /Disease: Y / N ____________ Thyroid Disease: Y / N ____________
Arthritis: Y / N ____________ Other: ____________

**** NEW PATIENTS**** whom may we thank for referring you to our office?

Family, friend or coworker. Who? ____________ Doctor. Who? ____________

Are you planning to get new glasses today? Y / N / Maybe **Are you planning to get new contact lenses? Y / N / Maybe**

Do you participate in a flexible spending account? Y /N

Island City Eyecare
Drs. Brauss, Shaffer, Jensen & Jensen
2301 Wilton Drive Unit C1
Wilton Manors, Fl 33305

RECEIPT OF NOTICE OF PRIVACY
PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

HIPAA

I, ____________________ have reviewed/received a copy of
Patient Name

Island City Eyecare's Notice of privacy practices.

____________________ ____________________
Patient/Guardian Signature **Date**

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE: **INITIALS:** **REASON:**