PUZIO
eyecare associates

MR. MRS. MS. DR. REV. Full Name: _____

Date of Birth: _____Gender: _____Marital Status:_____

Mailing Address:_____

Street Address:_____

Phone Number:_____CellPhone:_____Email:_____

Parent/Guardian Name: _____ Primary Care Physician Name:_____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Emergency Contact Name/Phone Number:_____

Please Circle reason for visit: Routine Examination Contact Lens Examination Emergency Other

Date of Last Eye Examination: _____ Date of Last Health Examination:_____

Who may we thank for referring you to us? _____

Medical Insurance: _____ Name of Insured:_____

ID #:_____ Group #:_____

Secondary Insurance:_____ Name of Insured:_____

ID #:_____ Group #:_____

Vision Insurance:_____ Name of Insured:_____

ID #:_____ Group #:_____

I prefer to be contacted by: EMAIL HOME TELEPHONE CELL PHONE TEXT MESSAGE

I authorize Puzio Eye Care to leave a message with any important health information. YES or NO

I authorize Puzio Eye Care to release any medical information to providers who request it. YES or NO

Please note: After 3 missed appointments or last minute cancellations, no future appointments will be scheduled. A patient may call in the morning for a same day appointment if there is time in the Doctor's schedule.

PUZIO
eyecare associates

I authorize Puzio Eye Care to disclose my past, present and future protected health information, including contact lenses, glasses and copies of prescriptions to the following people:

_____
____

I acknowledge that I was offered a copy of the NOTICE OF PRIVACY PRACTICES at Puzio Eye Care. I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurances/or amounts for services not covered by insurance carrier. If my insurance is a managed care plan requiring a referral from my Primary Care Provider (PCP), I understand that if I do not obtain this referral or if my PCP will not provide one, I will be responsible for any and all charges incurred during my treatment.

Signature:_____Print Name:_____Date: ____/____/____

PATIENT NAME:_____
OCCUPATION:_____

Patient Health (Please Circle YES or NO):

Amblyopia (Lazy Eye)	YES	NO	Eye Turn	YES	NO
Blurred Vision (Far)	YES	NO	Blurred Vision (Near)	YES	NO
Cataracts	YES	NO	Double Vision	YES	NO
Drooping Eyelid	YES	NO	Dry Eyes	YES	NO
Eye Surgeries	YES	NO	If yes, what type or surgery: _____		
Floaters/Spots	YES	NO	Fluctuating Vision	YES	NO
Burning Eyes	YES	NO	Watery Eyes	YES	NO
Foreign Body Sensation	YES	NO	Itchy Eyes	YES	NO
Allergies	YES	NO	Asthma/Respiratory	YES	NO
Blood Disorders	YES	NO	Cancer	YES	NO
Cardiovascular/ High BP	YES	NO	Diabetes	YES	NO
Headaches/Migraines	YES	NO	Heart Attack/Stroke	YES	NO
Kidney Disorders	YES	NO	Psychiatric/Depression	YES	NO
Thyroid/Endocrine Problems	YES	NO	Epilepsy	YES	NO

Family History-Blood Relatives (Please Circle YES or NO):

Amblyopia (Lazy Eye)	YES	NO	Cataracts	YES	NO

PUZIO
eyecare associates

Blindness YES NO Color Blindness YES NO

Diabetes YES NO Eye Turn YES NO

Glaucoma YES NO Macular Degeneration YES NO

Retinal Detachment YES NO High Blood Pressure YES NO

Other:

Tobacco/Alcohol Use YES NO Are you pregnant or nursing? YES NO

Do you have trouble driving at night? YES NO Do you wear sun protective eyewear? YES NO

Do you have problems with your vision when using the computer? YES NO

Do you wear contacts? YES NO Do you wear glasses? YES NO

If so, do you have any problems with your current pair?
_____

Do you have any medication allergies, or other type of allergies?
_____

Are you taking any medications (including over the counter eye drops)?
_____

_____
____

Please note: After 3 missed appointments or last minute cancellations, no future appointments will be scheduled. A patient may call in the morning for a same day appointment if there is time in the Doctor's schedule.