PATIENT INFORMATION

Today's Date: ___________

Name: ______________________________ Nickname: ___________ Gender: ___________
Date of birth: ______________ Patient SSN: ______________________________
Mailing Address: ____
____

Phone Number: ______________________________ Cell Phone: ______________________________
Email: ____________________ Preferred method of communication: ______________

Preferred Language: ____________________ Race: __________ Ethnicity: ________________
Primary Care Physician Name: ______________________________
Preferred Pharmacy: ____________________ Pharmacy Phone Number: ________________

Parent/Guardian Name: ____
Emergency Contact Name/Phone Number: ________________________________

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

Who may we thank for referring you to us? ________________________________
Did another doctor refer you to us? ____

INSURANCE INFORMATION

Medical Insurance: ________________ Name of Insured: ____________________
ID #: ______________________ Relationship of Insured: ____________________

Secondary Insurance: ________________ Name of Insured: ____________________
ID #: ______________________ Relationship of Insured: ____________________

Vision Insurance: ________________ Name of Insured: ____________________
ID #: ______________________ Relationship of Insured: ____________ DOB: _________

AUTHORIZATIONS

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

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

The Dr. may recommend a dilated eye exam to fully assess eye health. With dilation, drops are placed in the eyes to enlarge the pupils so that the Dr. can examine the eyes for any diseases. I authorize Puzio Eye Care to dilate my child's eyes today. YES or NO

PRIVACY PRACTICES for HEALTH INFORMATION

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 deductible, co-insurances/or amounts for services not covered by my 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.

I acknowledge that I was offered a copy of the Notice of Privacy Practices at Puzio Eye Care Associates.

I/we hereby authorize Puzio Eye Care to administer procedures as may be necessary for proper health care.

Patient/Guardian Signature: ________________ Print Name: ____________________ Date: _______

Matthew S. Puzio, O.D. **Elizabeth T. Potvin, O.D.** **Matthew J. Philibin, O.D.**

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PATIENT HISTORY

Today's Date: ____________ Name:_________________________________ Date of birth:____________

What brings you in to our office today? ____

Date of last eye examination: _____________ Date of last medical examination: __________________

Previous Eye Doctor: ________________________Primary Care Doctor: __________________________________

Does your child (check all that apply):

- ☐ wear prescription glasses ☐ wear prescription sunglasses
- ☐ wear contact lenses Brand of contacts:______________________
- ☐ have "back up" glasses ☐ have sports/safety eyewear

What are any specific problems that your child has with their vision, eyes, glasses or contact lenses?

____

How long has the problem been observed? ____

Would you like a contact lens evaluation today? YES NO MAYBE

Would you like to meet with an optician about glasses today? YES NO MAYBE

LIFESTYLE INFORMATION

What are your child's hobbies ____

School Name: ____________________ Grade: _________________________

Has your child had extra help or tutoring in school?

How would you describe your child's reading ability?

Does your child often loose their place when reading?

How much screen time does your child get during an average week?

FAMILY MEDICAL/EYE HISTORY

Have any family members been diagnosed with any of the following? Which family member?

- ☐ Blindness ___________________ ☐ Retinal Problems ________________
- ☐ Cataracts _________________ ☐ Macular Degeneration ______________
- ☐ Glaucoma _________________ ☐ Diabetes____________________
- ☐ Eye Tumor _________________ ☐ Lazy Eye____________________
- ☐ Eye Turn ________________ ☐ Other _________________________

What are the parents history with eyeglasses?

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PATIENT EYE HISTORY

Has your child experienced any of the following?

- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Misreads words/Letter reversals
- ☐ Headaches
- ☐ Eye fatigue/Tired eyes
- ☐ Eye turn/Crossed eyes
- ☐ Lazy eye/ Amblyopia
- ☐ Color Blindness
- ☐ Pain/Irritation/Itch/Swelling
- ☐ Severe sensitivity to light
- ☐ Flashes/Floaters/Spots
- ☐ White appearance in pupil
- ☐ Eye injury/Trauma/Abrasion
- ☐ Head Injury
- ☐ Other_______________

PATIENT MEDICAL HISTORY

Has your child ever been diagnosed or treated for problems relating to the following:

- ☐ Cancer
- ☐ Digestive
- ☐ Ear/Nose/Throat
- ☐ Kidney
- ☐ Sinus
- ☐ Genitourinary
- ☐ Neurological
- ☐ Muscle/Bone Arthritis
- ☐ Respiratory/Asthma
- ☐ Immune system
- ☐ Psychology
- ☐ Skin
- ☐ Heart attack/Stroke
- ☐ Diabetes/Endocrine
- ☐ High blood pressure
- ☐ Blood/Lymph
- ☐ Cholesterol
- ☐ Reproductive
- ☐ Allergies
- ☐ STD
- ☐ Other health problems _______________

Did your child have a premature birth? At how many weeks?

Any complications during pregnancy?

Any complications during delivery?

Has your child shown normal development?

Has your child had physical/developmental therapy?

Has your child had any surgeries?

Do you have any allergies to medications: _______________

Please list current medication including eye drops and over - the - counter:

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