Flory Optometry, P.A.

Patient Information

Last: _____

First: _____ MI: _____

Preferred Name (if different): _____

Date of Birth: _____/_____/_____

Sex: M F Social Security #_____

Race: ❑ American Indian ❑ Asian ❑ African American

❑ Hispanic ❑ White ❑

Other_____

Address: _____

City: _____ State: ____ Zip: _____

Phone: Home _____

Cell _____

Email: _____

Employer: _____

Occupation: _____

❑ Full Time ❑ Part Time ❑ Student ❑ Retired

Marital Status: ❑ Single ❑ Married ❑ Widowed

Emergency Contact:
Name _____ Phone# _____

Relationship: _____

New Patients Only:
How did you choose our office?

- ❑ Family
- ❑ Friend
- ❑ Facebook
- ❑ Search engine
- ❑ Yellow Pages
- ❑ Driving by
- ❑ Insurance company
- ❑ Doctor's Referral

Insurance Information

If you are the insurance holder, please skip this section.

Person who is primary to your insurance:

Last _____ First _____ MI _____

Date of Birth _____ Relationship _____

Social Security# _____ Phone# _____

Address _____

City _____ State _____ Zip _____

Employer_____

Medical / Vision Insurance _____

Patient Medical History

Primary Physician: _____

Pharmacy: _____

Current Medications & Dosage (RX / over-the-counter)

_____

_____

_____

Allergies to medications? ❑ Yes ❑ No

If yes, what medications? _____

_____

Have you had eye surgery? ❑ Yes ❑ No

If yes, please list type and date: _____

_____

Patient Medical History

In the past year, have you been diagnosed with or treated for the following health issues:

Anemia	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Cancer (type: _____)	❑ Yes	❑ No
Diabetes (type: _____)	❑ Yes	❑ No
Hearing Loss	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
HIV/AIDS	❑ Yes	❑ No
Kidney Disorder	❑ Yes	❑ No
Liver Disorder	❑ Yes	❑ No
Psychological Disorder	❑ Yes	❑ No
Seasonal Allergies	❑ Yes	❑ No
Seizures	❑ Yes	❑ No
Thyroid Disorder	❑ Yes	❑ No

If answered YES to any of the above or have a condition not listed, please explain: _____

_____

_____

Family Medical / Eye History

Is there a family medical history of the following?

If yes, please list relationship:

Diabetes _____

Heart Disease _____

Glaucoma _____

Macular Degeneration _____

Retinal Disorder _____

Vision Loss _____

Other _____

Patient Eye History

Have you experienced or been treated for any of the following eye problems in the last three years:

❑ Blurry vision	❑ Burning
❑ Cataracts	❑ Corneal abrasions
❑ Crossed eyes/eye turn	❑ Dry eye
❑ Eye infections	❑ Double vision
❑ Eye fatigue	❑ Eye injury
❑ Flash of light	❑ Excess tearing
❑ Glaucoma	❑ Floaters/spots
❑ Headaches	❑ Foreign body
❑ Itchiness	❑ Grittiness
❑ Light sensitivity	❑ Iritis/uveitis
❑ Macular Degeneration	❑ Lazy eye
❑ Retinal Detachment	❑ Ocular dryness

If answered YES to any of the above or have a condition not listed, please explain: _____

_____

_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process my insurance claim. I also request government benefits either to myself or to the party who accepts the assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits including Medicare to Steven J. Flory, O.D. for services rendered.

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I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. Payment is due when services are rendered. Materials ordered (i.e. glasses or contact lenses) require a deposit of 100% with the balance due upon delivery. We will assist you in completing any insurance forms so that you may be reimbursed from your insurance carrier. This office cannot accept responsibility for collecting your insurance claim. Accounts that are over 30 days past due will be subject to a 1.5% monthly finance charge. There will be a $30.00 fee on returned checks

_____ _____ _____

Patient/Guardian Signature **Date** **Doctor Review Signature**