WELCOME TO OUR OFFICE!

Thank you very much for choosing Dr. Lewis Frey's Office for your eye care needs.

Circle One: Mr. Mrs. Ms. Miss Dr. Today's Date ____________________

Last Name:____________________ First Name:____________________ MI: ______

Preferred Name:____________________

Address:____________________ City:____________ State: _____ Zip____________

SSN:_____-_____-_______ Sex: ☐ M ☐ F Date of Birth: ___/___/_____ Age ____________

Home Phone #: ____________________ Cell Phone #: ____________________

Work Phone #: ____________________ Email Address: ____________________

Preferred Language: ____________________

Race/Ethnicity: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Hispanic ☐ Pacific Islander

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor ☐ Other

Employment Status: ☐ Full-time ☐ Part-time ☐ Student ☐ Retired ☐ Not Employed

Employer/School: ____________________ Occupation:____________________

INSURANCE INFORMATION

Medical Insurance Company: ____________________ ID#____________________

Primary Insured Name:____________________ Primary's SS# ____________________

Primary's Date Of Birth: ____________________ Relationship to Patient:____________________

Do you have a **Vision Insurance** policy separate from your medical insurance? ☐ Yes ☐ No

Vision Insurance Company: ____________________ ID# ____________________

Primary Insured Name:____________________ Primary's SS# ____________________

Primary's Date Of Birth: ____________________ Relationship to Patient:____________________

Do you have a **Secondary** Insurance or a **Supplemental** Insurance? ☐ Yes ☐ No

Secondary/Supplemental Insurance Co.:____________________ ID#:____________________

Primary Insured Name:____________________ Primary's SS# ____________________

Primary's Date Of Birth: ____________________ Relationship to Patient:____________________

PATIENT MEDICAL HISTORY FORM

Name__________________________ DOB _____________________ Today's Date __________________________

PATIENT'S OCULAR/MEDICAL/SOCIAL HISTORY

Do you have any allergies to medications? ☐ Yes ☐ No. If yes, please list____

List all the medications you are currently taking: ____

List all the major eye injuries or surgeries you have had: ____

Height:________ft________in Weight:___________________lbs

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your current pair of glasses?____________________

Do you wear contact lenses? ☐ Yes ☐ No Type of contact lenses:______________________________________

Please check any conditions that you have or have had in the past:

☐ Blurred Vision	☐ Macular Degeneration	☐ Diabetes	☐ Arthritis
☐ Loss of Vision	☐ Glaucoma	☐ High Blood Pressure	☐ Anemia
☐ Double Vision	☐ Eye Pain	☐ High Cholesterol	☐ Anxiety/Depression
☐ Crossed Eyes	☐ Excessive Tearing	☐ Stroke	☐ Sinus Congestion
☐ Lazy Eye	☐ Dryness of Eyes	☐ Headache	☐ Asthma
☐ Eye Surgery	☐ Itching/Burning	☐ Migraine	☐ Emphysema
☐ Cataract	☐ Mucus Discharge	☐ Seizure	☐ HIV
☐ Retinal Detachment	☐ Eye Injuries	☐ Thyroid	☐ Other: ________________
☐ Flashes/Floaters	☐ Eye Infection/Redness	☐ Cancer	

Do you use tobacco products? ☐ Never ☐ Former User ☐ Current User Number of years:________________________

Do you drink alcohol? ☐ Yes ☐ No (If yes) how often:____

FAMILY HEALTH HISTORY

Please mark any conditions that apply to your immediate family members by filling in one or more of the following letters:

F – Father, M – Mother, SI – Sister, B – Brother, SO – Son, D – Daughter

________Blindness	________Glaucoma	________Heart Disease	________Thyroid Disease
________Cataracts	________Macular Degeneration	________High Blood Pressure	________High Cholesterol
________Crossed Eyes	________Retinal Detachment	________Lupus	________Other: ________________
________Diabetes	________Rheumatoid Arthritis	________Cancer, If so, Type _______________________________	

NOTICE OF PRIVACY

The Health Insurance Portability and Accountability Act (HIPPA) is a federal law designed to protect the privacy of your health information. We understand that the information about you and your health is personal, and at Lewis Frey OD, PC, we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls.

By signing below, I acknowledge that I have read/received the copy of the Notice of Privacy Practices for review.

____ ____________________________

(Patient's Signature or Legal Representative) (Date)