Welcome to Nordin Eye Center

Appointment Date _____

Patient's Name (please print) _____

If a Child, Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ / Alt. Phone _____

E-mail Address _____

Birth Date _____ Age _____ M or F _____ SSN _____

Employer _____ Occupation _____

Spouse's Employer _____ Work Phone _____

Account Responsible

If different from above

Person Responsible for Account _____
LAST NAME FIRST NAME INITIAL

Relation to Patient _____ Birth Date ____/____/____ Soc. Sec. # _____

Address (if different form patient) _____

City _____ State _____ Zip Code _____ Preferred Phone _____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date _____

ACKNOWLEDGMENT RECEIPT

By initialing below, I acknowledge I have been offered a copy of Nordin Eye Center's Notice of Privacy Practices.

___Yes, I would like to receive a copy of Nordin Eye Center's Notice of Privacy Practices.

___No, I do not wish to receive a copy of Nordin Eye Center's Notice of Privacy Practices.

HEALTH QUESTIONNAIRE

Date of last physical _____ Name of Physician _____

DO YOU CURRENTLY HAVE OR HAD ANY OF THE FOLLOWING CONDITIONS?

- ☐ Diabetes
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Thyroid Problem
- ☐ Anxiety/Depression
- ☐ Respiratory Problems
- ☐ Stroke/Neurological
- ☐ Cardiovascular Problems
- ☐ Blood Clot/Bleeding
- ☐ Sickle Cell/Anemia
- ☐ Hepatitis
- ☐ Arthritis
- ☐ HIV/Aids
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Are You Pregnant?
- How Far Along: _____
- ☐ Kidney Problems
- ☐ Skin Disorders
- ☐ Other _____

Date of Last eye exam _____

HAVE YOU EVER BEEN TREATED FOR OR DIAGNOSED WITH ANY OF THE FOLLOWING?

- ☐ Cataracts
- ☐ Amblyopia/Lazy Eye
- ☐ Strabismus/Crossed Eye
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Problems
- ☐ Eye Infection
- ☐ Eye Surgery
- ☐ Eye Trauma
- ☐ Blindness

DO YOU HAVE A FAMILY HISTORY OF THE FOLLOWING?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Blindness
- ☐ Glaucoma
- ☐ Amblyopia/Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Strabismus/Crossed Eyes
- ☐ Cataracts

DO YOU EVER EXPERIENCE ANY OF THE FOLLOWING?

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Unexplained Headache

PLEASE LIST ALL MEDICATIONS:

PLEASE LIST ALL ALLERGIES:

HOW DID YOU HEAR ABOUT US?

☐ Internet ☐ Newspaper ☐ Phone Book ☐ Friend/Family ☐ Drive-by ☐ Other _____

PLEASE LIST HOBBIES/INTERESTS: