Lori J. Bende, OD, Professional Optometric Corporation

WELCOME!

THANK YOU FOR UPDATING YOUR INFORMATION EVERY YEAR

Name _____ DOB _____/_____/_____ SSN _____

Address_____ Apt. # _____ City_____ State_____

Zip Code _____Home Phone_____ Work phone_____

Cell Phone_____ Employer _____Occupation_____

E-Mail _____ Marital Status _____

Emergency Contact_____ Phone_____ Relationship _____

How did you hear about us? _____ Referred? _____

INSURANCE INFORMATION

Please provide your medical and vision insurance card to the front desk

Vision Insurance *(please circle):* VSP MES EYEMED MEDICARE Other_____

Name of Insured _____ DOB _____/_____/_____ Insured SSN_____

Medical Insurance

Company/Group Name _____ Flexible Spending Account? YES / NO

MEDICAL HISTORY

What is the main reason for your visit today? _____

How many hours per day do you use the computer? _____ Hobbies? _____

Primary Care Physician _____Phone_____ Last Physical Exam _____

How is your general health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent (Pregnant? YES / NO / Not Applicable)

In addition to your yearly eye exam would you like to be fitted for or renew your contacts today? YES / NO

Please list any current medications including over the counter medications you are taking:

- _____ - _____ - _____
- _____ - _____ - _____

Continued on back…

GOLDEN TRIANGLE OPTOMETRIC CENTER

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Check all that apply:	Y	N	Please Explain
Diabetes			
Allergies/ Medication Allergy			
High Blood Pressure			
Headaches			
Surgeries			
Cigarette/Tobacco use			
Alcohol			

Do you have problems with any of these systems?	Y	N	Explain (include type & date of diagnosis if applicable)
Cardiovascular/Vascular (Diabetes, hypertension)			
Ear, Nose, Throat, Mouth (Sinus Congestion)			
Respiratory (Asthma, Bronchitis, Emphysema)			
Gastrointestinal (Kidney, Bladder)			
Musculoskeletal (Arthritis, Joint/Muscle Pain)			
Integumentary (Skin)			
Neurological (Headaches, Migraines, Seizures)			
Psychiatric			
Endocrine (Thyroid, Other Gland)			
Hematologic/Lymphatic (Anemia, Bleeding)			
Allergic/Immunologic			

PERSONAL EYE INFORMATION	Y	N	Please Explain
Eye Surgeries/Injury			
Eye Fatigue			
Dry Eyes			
Blurred Vision			
Flashes - Floaters - Halos			
Double Vision			
Other Eye Conditions			

FAMILY HISTORY	Y	N	Who in your family has had the following?
High Blood Pressure			
Macular Degeneration			
Diabetes			
Cancer			
Glaucoma			
Retinal Detachment			
Other Eye Conditions			

I acknowledge receipt of Golden Triangle Optometric Center's Notice of Privacy Practice

X _____ Date completed_____