DR. M. MORSE MICHELS, PC.

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THERAPEUTIC OPTOMETRIST ~ PRIMARY CARE ~ CONTACT LENS SPECIALIST
DRY EYE & GLAUCOMA SPECIALIST ~ MYOPIA CONTROL

PATIENT INFORMATION

DATE _____ TIME _____ NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ DAY _____ CELL _____

DATE OF BIRTH _____ HEIGHT _____ AGE _____

SOCIAL SECURITY # _____ LANGUAGE ENGLISH _____ SPANISH _____

RACE
_____ AMERICAN INDIAN OR ALASKA NATIVE
_____ BLACK OR AFRICAN AMERICAN
_____ HISPANIC
_____ WHITE
_____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLAND

ETHNICITY
_____ HISPANIC OR LATINO
_____ NATIVE HAWAIIAN / OTHER PACIFIC ISLAND
_____ NOT HISPANIC OR LATINO

COMMUNICATION PREFERENCE ~ PHONE _____ POSTAL _____ E-MAIL _____

MARITAL STATUS
_____ SINGLE
_____ DIVORCED
_____ LEGALLY SEPARATED
_____ MARRIED
_____ WIDOWED

EMPLOYMENT STATUS
_____ FULL TIME STUDENT
_____ SELF EMPLOYED
_____ FULL TIME
_____ PART TIME
_____ UNEMPLOYED
_____ PART TIME STUDENT
_____ NOT A STUDENT
_____ ACTIVE MILITARY DUTY
_____ RETIRED

OCCUPATION _____ HOBBIES _____

EMERGENCY CONTACT _____ PHONE _____

ADDRESS _____

PHYSICIAN NAME _____ PHONE _____

DATE OF LAST PHYSICAL _____ DATE OF LAST EYE EXAM _____

REFERRING PARTY _____ CURRENT PHARMACY _____

PHARMACY ADDRESS _____

REASON FOR VISIT

_____ EYE PAIN RIGHT _____ LEFT _____ BOTH DESCRIBE PAIN _____
_____ EYE EXAM _____ NEED GLASSES _____ CONTACT EVALUATION
_____ NEW WEARER, INTERESTED IN CONTACTS _____ CURRENTLY USE CONTACTS HOW LONG _____ WHAT PRODUCT _____
_____ BLURRED VISION NEAR____ FAR____ BOTH____ RIGHT____ LEFT____ BOTH____
_____ BLURRED NIGHT VISION NEAR____ FAR____ BOTH____ RIGHT____ LEFT____ BOTH____
_____ ALLERGIES
_____ CATERACT
_____ CONTACT LENS DISCOMFORT
_____ DIABETES
_____ DOCTOR RECOOMENDED VISIT
_____ DOUBLE VISION
_____ DRY EYE
_____ EYE ITCH
_____ EYE STRAI COMPUTER
_____ EYE STRAIN/FATIGUE
_____ LASIK
_____ CURRENT OR PAST EYE TRAUMA OR SURGERY
_____ FIELD VISION LOSS
_____ FLASHES OF LIGHT
_____ FLOATERS
_____ FOREIGN BODY SENSATION
_____ GROWTH IN OR AROUND EYE
_____ GLAUCOMA EVALUATION
_____ GLAUCOMA FOLLOW-UP
_____ HEADACHES
_____ LID TWITCHING
_____ LIDS STICK TOGETHER
_____ FIELD VISION LOSS
_____ RIGHT _____ LEFT
_____ LIGHT SENSITIVITY
_____ MUCOUS DISCHARGE
_____ PHOTOPHOBIA
_____ POST OP CATARACT
_____ POST OP LASIK
_____ REDNESS IN OR AROUND EYES
_____ SCRATCHY OR GRITTY
_____ WATERY / TEARING EYES
_____ OTHER
_____ LIGHT SENSITIVITY
_____ LIGHT SENSITIVITY
_____ BOTH DATE _____

FAMILY HISTORY

HEART DISEASE	SELF	M	F	SIB	GP	HYPERTHYROID	SELF	M	F	SIB	GP
DIABETES	SELF	M	F	SIB	GP	CATARACT	SELF	M	F	SIB	GP
CANCER	SELF	M	F	SIB	GP	GLAUCOMA	SELF	M	F	SIB	GP
STROKE	SELF	M	F	SIB	GP	ALTZHEIMERS	SELF	M	F	SIB	GP
ARTHRITIS	SELF	M	F	SIB	GP	HYPERTENSION	SELF	M	F	SIB	GP
HIV POSITIVE	SELF	M	F	SIB	GP	OCULAR HERPES	SELF	M	F	SIB	GP
AIDS	SELF	M	F	SIB	GP	SMOKER	SELF	M	F	SIB	GP

WHAT MEDICATIONS ARE YOU ALLERGIC TO?

LIST ANY MEDICATIONS YOU CURRENTLY TAKE AND DOSAGE

EYE MEDICATIONS/DROPS YOU CUREENTLY USE OR HAVE USED WHEN AND DOSAGE

PLEASE LIST ANY ADDITIONAL CONCERNS YOU WOULD LIKE DR. MICHELS TO BE AWARE OF

INSURANCE INFORMATION

METHOD OF PAYMENT _____CHECK _____CASH _____CREDIT CARD _____OTHER

INSURANCE CARRIER _____ ID#_____

PRIMARY MEMBER NAME _____ DATE OF BIRTH _____

PRIMARY CARD HOLDER SOCIAL SECURITY # _____

VISION INSURANCE _____ ID# _____

THE OFFICE POLICY IS TO PAY FOR THE EXAMINATION WHEN SERVICES ARE RENDERED. YOU ARE RESPONSIBLE FOR ANY DEDUCTIBLE YOU HAVE NOT MET OR FOR ANY ALLOWANCES WICH YOUR INSURANCE COMPANY DOES NOT COVER. ONE-HALF DEPOSIT IS REQUESTED UPON ORDERING GLASSES OR CONTACTS WITH THE BALANCE PAID IN FULL UPON PICK-UP. THANK YOU FOR YOUR COOPERATION.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I HERBY AUTHORIZE DR. M MORSE MICHELS TO RELEASE MEDICAL INFORMATION FROM THE RECORD OF:

PATIENT NAME _____ DATE OF BIRTH _____

COVERING THE PERIOD (S) OF CARE FROM THIS DATE _____

_____ X-RAYS _____MEDICATION RECORDS _____THERAPY NOTES _____HISTORY

OTHER _____

_____ _____ _____

SIGNATURE OF PATIEN/AUTHORIZED REPRESENTATIVE RELATIONSHIP TO PATIENT DATE