OLSON OPTICAL

Welcomes You !

Please complete this form accurately as it keeps your records up to date. This information becomes part of your permanent record and as such is held in complete confidence unless you authorize its release in writing. We will contact you at any of the below address/phone #'s unless otherwise instructed. Please see our Notice of Privacy Policy.

Name_____Birth Date: _____ Age_____

Spouse:_____ OR Parent(s) names _____

Address_____City_____Zip_____

Phone #'s Home:_____ Cell : _____

Work Place:_____ Work Phone:_____ Ext _____

SS # _____/_____/_____ (OPTIONAL unless required for insurance billing)

E-Mail Address:_____

We would like to be able to correspond with you via email! Do you check this regularly? Yes No

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How were you recommended to our office? (Circle any that apply)

Another Person (please name):_____

Other type: _____

Our Website
I am a Previous Patient
Our Billboard
Newspaper Ad
My Vision Plan/Insurance
Radio

Please list any Insurance/Vision Plan coverage for your exam or glasses below:

_____

Check out our WEBSITE @: www.olsonoptical.com

▪ email us ▪ schedule or confirm appointments ▪ order contacts ▪ ask us a question

PLEASE CONTINUE ON THE OTHER SIDE →

1) Is this visit routine? Yes No 2) Do you smoke? Yes No

3) Are you experiencing any specific problems with your glasses, contacts or your eyes? Yes No

If yes, please list and explain any specific problems you are having: _____

_____

4) Have you ever had "double vision" or a "prism" correction in your glasses? Yes No

5) If elsewhere, when was your last eye examination? _____ Where were you seen last?_____

If needed, may we request your previous records? Yes No

6) If your eyes are dilated today, are you able to drive or do you have a driver with you? Yes No

7) Do you currently wear glasses? Yes No If yes, how old are they? _____

8) Do you wear contact lenses? Yes No If yes, what type?_____

What replacement schedule do you follow? Daily 2-week 1 month Other: _____

9) Would you like to trial contact lenses? Yes No

10) Do you have any allergies? Yes No If yes, what are they?_____

11) Have you ever had cataract surgery, eye surgeries, laser procedures or eye injuries? Yes No

If yes please list:_____

12) Circle any health conditions you have: Diabetes Glaucoma High Blood Pressure High Cholesterol Pregnancy

List any others including any recent hospitalizations:_____

13) Do you take any medications for these conditions? Yes No

What do you take? (Please include over-the-counter medication, vitamins, herbal supplements, pre-natal vitamins, etc.)

If you don't know the specific name of the drug, please list what you take it for.

_____

_____

- I understand this office will act as my agent in obtaining payment from my Insurance company; however, I further understand that I am ultimately responsible for my bill, including services NOT covered by Medicare or my Supplement.
- I understand that in the course of providing services to me, this office creates stores and receives information that identifies me. I authorize this office to use and disclose this identifying information as necessary for my treatment, payment and healthcare operations and that this information will only be released in accordance with this office's Notice of Privacy Policy.
- I authorize payment from any Insurance company to be made directly to Olson Optical.
- I acknowledge that I may read/take a copy of this office's Notice of Privacy Practice which is on the front desk counter and that I will ask the receptionist if I have any questions or do not readily see it.
- I permit a copy of this authorization to be used in place of the original and certify all the information above is accurate to the best of my knowledge.

X_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE