

# Hometown Eyecare and Optical, LLC

## Patient Information

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City, Zip \_\_\_\_\_ Sex:  Male  Female  
Employer/School: \_\_\_\_\_  
Please place a check in the box indicating your preferred phone #  
Occupation: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Primary Insurance Cardholder: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_

**How would you like to be reminded of your next annual appointment?:**  Text  Post Card

## Patient Medical History

Name of Medical Doctor: \_\_\_\_\_

### Please check any conditions that apply to you

#### Constitution

Developmental Disabilities  
 Cancer

#### Ear/Nose/Throat

Hearing Loss  
 Sinusitis  
 Other \_\_\_\_\_

#### Neurological

Multiple Sclerosis  
 Migraine  
 Autism Spectrum Disorder  
 Other \_\_\_\_\_

#### Psychological

Depression  
 Attention Deficit  
 Anxiety Disorder  
 Other \_\_\_\_\_

#### Cardiovascular

High Blood Pressure  
 Stroke  
 Heart Disease  
 Congestive Heart Failure  
 Other \_\_\_\_\_

#### Respiratory

Asthma  
 Emphysema  
 Sleep Apnea  
 Other \_\_\_\_\_

#### Gastrointestinal

Ulcers  
 Acid Reflux/Gerd  
 Celiac Disease  
 Other \_\_\_\_\_

#### Genitourinary

Kidney Disease  
 Prostate Cancer  
 Benign Prostate Hypertrophy  
 STD  
 Other \_\_\_\_\_

#### Musculoskeletal

Arthritis  
 Fibromyalgia  
 Muscular dystrophy  
 Osteoporosis  
 Gout  
 Other \_\_\_\_\_

#### Integumentary/Skin

Eczema  
 Rosacea  
 Psoriasis  
 Herpes Simplex/Cold sores  
 Herpes Zoster {Shingles}  
 Other \_\_\_\_\_

#### Endocrine

Type 1 Diabetes  
 Type 2 Diabetes  
 Thyroid Dysfunction  
 Hormone Dysfunction  
 Other \_\_\_\_\_

#### Hematologic/Lymphatic

Anemia  
 Blood loss  
 High Cholesterol  
 Other \_\_\_\_\_

#### Immune System

AIDS  
 Lupus  
 Sjogren's Syndrome  
 Other \_\_\_\_\_

Are you pregnant or nursing  Yes  No

Are you allergic to any medications?  Yes  No

If yes, what medications? \_\_\_\_\_

Please list any other allergies (food, environmental, etc.) \_\_\_\_\_

# Hometown Eyecare and Optical, LLC

## Have you ever experienced or been diagnosed with any of the following? (Please check)

Glaucoma                       Double Vision                       Eye Infections                       Flashes of Light in your vision  
 Cataracts                       Crossed Eye/Eye turn                       Watery Eyes                       Floaters in your vision  
 Macular Degeneration                       Amblyopia                       Chronic Headaches                       Dry/Itchy Eyes  
 Retinal Detachment                       Keratoconus  
 Eye Injury {please explain} \_\_\_\_\_  
 Eye Surgery {please explain} \_\_\_\_\_  
 Other \_\_\_\_\_

## Do you use: (please circle)    [ ] Check if none of these apply to you

Alcohol    Chewing tobacco    Cigarettes    Cigars    Pipes    Vaping    Former smoker

## Current Medications (Rx or Over the Counter) Please list any medications you are currently using.

If you take more medications than the area provided, please provide a list for us to copy

\_\_\_\_\_  
\_\_\_\_\_

## Family Medical and Eye History

Please note who of your **Parents, Siblings, or Children** have any of the following:

Cancer \_\_\_\_\_                      Hypo Thyroid \_\_\_\_\_  
Type 1 Diabetes \_\_\_\_\_                      Cataracts \_\_\_\_\_  
Type 2 Diabetes \_\_\_\_\_                      Macular Degeneration \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_                      Glaucoma \_\_\_\_\_  
Hyper Thyroid \_\_\_\_\_                      Retinal Detachment \_\_\_\_\_  
Other Significant family history {Please specify} \_\_\_\_\_

## Please indicate that you understand and agree to the following: (Parent/guardian initial for minor patient)

\_\_\_\_\_ I acknowledge that I have seen a copy of and have reviewed Hometown Eyecare and Optical's Notice of Privacy Practices.

\_\_\_\_\_ I give Dr. Walton and his staff consent to view my prescription medications claims history and I understand that they will have access to this history through an online pharmacy database until I choose to revoke this consent.

\_\_\_\_\_ I request that payment of authorized insurance benefits for any services provided on my behalf be made to Hometown Eyecare and Optical, LLC. I authorize any holder of medical information about me to release to my insurance companies, and their agents, any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges of services not covered by my insurance. I understand that if I have no vision and/or medical insurance, I am responsible for the self-payment amount. If legal actions are necessary due to outstanding statements, I am responsible for any collections, court, and attorney fees.

## Please list anyone that you would like to authorize access to your medical records/information if needed

\_\_\_\_\_  
\_\_\_\_\_

## Patient Signature

(Or Guardian if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_