

John J. Tracy, O.D.

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Today's Date: _____ Dr. Mr. Mrs. Miss Ms. Male Female Age _____

Patient's First Name _____ Last Name _____ Date of Birth _____ SS# _____

Address _____ City _____ Zip _____

Phone: Home _____ Cell _____ Work _____ E-mail Address _____

Occupation _____ Employer _____ Date of last eye exam _____

IF PATIENT IS A CHILD: Parent's Name _____ School _____ Grade _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Family Friend Name: _____ Phone Book Internet Other _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company _____ Full Name of Insured Member _____ Member Date of Birth _____

Insured's Identification number _____ Group Number _____

Insured is: Male Female Relationship to Insured Self Spouse Child Other _____

PLEASE CHECK ANY OF THE FOLLOWING REASONS FOR THIS EXAM:

New eyeglasses Computer lenses Eye health examination Reading glasses Contact lenses Other

DESCRIBE YOUR INTEREST IN LASER VISION CORRECTION: Very interested Interested Thought about it Not interested

GENERAL INFORMATION

Do you wear glasses? Y/N

How many years? _____

Are glasses for distance? Y/N

Are glasses for reading? Y/N

Do you wear contact lenses? Y/N

What type: Soft / Hard / Daily / Disposable

Bifocal contacts / Colored / Extended wear

Do you work on a computer? Y/N

How many hours daily? _____

To help us provide you with the best vision, please check any of the activities that apply to your lifestyle in work or pleasure.

<input type="checkbox"/> Accounting	<input type="checkbox"/> Driving	<input type="checkbox"/> Piano	<input type="checkbox"/> Team sports
<input type="checkbox"/> Bicycling	<input type="checkbox"/> Fishing	<input type="checkbox"/> Playing cards	<input type="checkbox"/> Television
<input type="checkbox"/> Computer use	<input type="checkbox"/> Flying	<input type="checkbox"/> Racquetball	<input type="checkbox"/> Tennis
<input type="checkbox"/> Crafts	<input type="checkbox"/> Gardening	<input type="checkbox"/> Reading	<input type="checkbox"/> Video games
<input type="checkbox"/> Data entry	<input type="checkbox"/> Golf	<input type="checkbox"/> Running	<input type="checkbox"/> Water sports
<input type="checkbox"/> Desk work	<input type="checkbox"/> Machine operator	<input type="checkbox"/> Sewing	<input type="checkbox"/> Woodworking
<input type="checkbox"/> Drafting	<input type="checkbox"/> Motorcycle riding	<input type="checkbox"/> Skiing	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Drawing	<input type="checkbox"/> Needlework	<input type="checkbox"/> Studying	_____

MEDICAL INFORMATION

How is your general health? _____

Do you have problems with any of these systems?

Check the box if apply.

<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Nerves	<input type="checkbox"/> Endocrine (glands)
<input type="checkbox"/> Ears/Nose/Throat	<input type="checkbox"/> Urinary	<input type="checkbox"/> Blood/Lymph
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Skin	<input type="checkbox"/> Muscles/Bones
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Weight	<input type="checkbox"/> Allergic/Immunologic
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mental	<input type="checkbox"/> Headaches

Please explain: _____

Diabetes Type _____ Date of diagnosis _____

Other Health problems _____

Allergies to Medication Y / N Which? _____

Reactions? _____

Current medication(s) _____

Surgeries Date _____

Kind _____

Name of family doctor _____

Date of last visit _____

FAMILY HISTORY

High Blood pressure Y / N Relation

Macular degeneration Y / N Relation

Diabetes Y / N Relation

Retinal detachment Y / N Relation

Glaucoma Y / N Relation

Cataracts Y / N Relation

Amblyopia (lazy eye) Y / N Relation

Eye turn Y / N Relation

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc?)

Y / N Type _____

Do you engage in regular exercise?

Y / N

Do you drink alcohol? Y / N If yes, how much

Occasional 1 Per Day 2-3 /Day / Week

4+ /Day / Week

Do you smoke? Y / N If yes, how much

Occasional 1/2 Pack/Day 1 Pack/Day

1+ /Pack

Method of tobacco intake: Smoking Chewing

Do you use illegal drugs: Y / N

PERSONAL EYE INFORMATION

Have you had any eye surgeries? Y / N

Type _____ Date _____

Have you had an eye injury? Y / N

Type _____ Date _____

Do you have?

Glaucoma Y / N

Cataracts Y / N

Dry eyes Y / N

Macular degeneration Y / N

Retinal detachment Y / N

Blurred vision Y / N

Additional information: _____

OTHER FAMILY MEMBERS STILL LIVING AT HOME:

Spouse _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

I understand that if my insurance eligibility cannot be verified, or if my insurance does not pay the amount due to my account, that I will be financially responsible for payment of all charges incurred for services received from **John J. Tracy, O.D.**

Each prescription is ground to the exact specifications required for your eyes. Therefore a deposit of at least 50% will be required before any glasses or contacts lenses will be ordered. The remaining balance must be paid when you pick up your prescription. Insurance co-payments are due at the time of service.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** is available at www.drjtracy.com or in our office and describes these uses and disclosures in detail. **I acknowledge that I have received the Notice of Privacy Practices from John J. Tracy, O.D.**

Signature _____ Date _____ Relationship to Patient _____