

MICHAEL HANDY, O.D.  
OPTOMETRIST  
WELCOME TO OUR OFFICE

DATE \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME # \_\_\_\_\_ DAYTIME # \_\_\_\_\_ CELL # \_\_\_\_\_

SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ M or F \_\_\_\_\_

REASON FOR TODAY'S VISIT \_\_\_\_\_

DO YOU WORK WITH A COMPUTER \_\_\_\_\_ HOURS PER DAY \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

MEDICAL HISTORY

Do you have any health problems in the following areas?

Ears Y or N Eyes Y or N Nose Y or N Throat Y or N Cardiovascular Y or N Respiratory Y or N

Gastrointestinal Y or N Endocrine (glands) Y or N Blood Y or N Skin Y or N

If Y please explain \_\_\_\_\_

Please answer all that apply to **yourself** / family history of:

High Blood Pressure Y or N who \_\_\_\_\_: Headaches Y or N who \_\_\_\_\_: Arthritis Y or N who \_\_\_\_\_

Cigarettes Y or N Tobacco Y or N Alcohol Y or N : Glaucoma Y or N who \_\_\_\_\_

Cataracts Y or N who \_\_\_\_\_: Macular Degeneration Y or N who \_\_\_\_\_

Allergies Y or N to what \_\_\_\_\_

Diabetes Y or N who \_\_\_\_\_ Diabetic Medication and dosage \_\_\_\_\_

Retinal Detachment / Disease Y or N \_\_\_\_\_: Eye Surgery Y or N: Type \_\_\_\_\_

CURRENT MEDICATION \_\_\_\_\_

RESPONSIBLE PARTY FOR BILLING: SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ PARENT \_\_\_\_\_

SUBSCRIBERS NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_

SUBSCRIBER PLACE OF EMPLOYMENT \_\_\_\_\_

**INSURANCE POLICIES are an arrangement with the CARRIER and the Patient. OUR OFFICE WILL BILL AS A COURTESY. THE PATIENT IS RESPONSIBLE FOR ALL PAYMENTS THAT ARE NOT PAID BY THE INSURANCE COMPANY OR GROUP.**

**ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. BY SIGNING THIS FORM YOU ARE GIVING DR. MICHAEL HANDY PERMISSION TO USE AND DISCLOSE YOUR PROTECTION IN ACCORDANCE WITH ALL EXISTING PRIVACY LAWS.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_