ROBERT L. STAPLES, O.D.

Last Name: _____

First Name: _____ Nickname: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone (if different): _____

Cell Phone: _____ May we text you: Y N

E-Mail Address: _____

Referred By: _____

Sex: M F Date of Birth: _____

Social Security Number: _____

Marital Status: _____

Employment Status: _____

Employer: _____ Occupation: _____

Preferred Language: _____

Race:

- Native American/Native Alaskan ☐
- Asian ☐
- Black/Africian American ☐
- Hispanic ☐
- Native Hawaiian/Other Pacific Island ☐
- White ☐

Ethnicity:

- Hispanic/Latino ☐
- Native Hawaiian/Other Pacific Island ☐
- Not Hispanic/Latino ☐

Communication Preferred: Email Telephone Postal

Last Eye Exam: _____ Doctor: _____

PATIENT HEALTH HISTORY

Patient Name: _____ DOB: _____

Primary Care Physician: _____ Date Last Seen: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy):_____

_____

_____

List all major surgeries (Eye Surgery included):_____

_____

List any allergic reactions to medications or eye drops: _____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself Yes	Yourself No
Cataract	·	·
Eye Turn	·	·
Glaucoma	·	·
Macular Degeneration	·	·
Retinal Detachment	·	·

	Yes	No
Women- Are you pregnant?	·	·
Are you breast feeding?	·	·

	Family Member Yes	Family Member No	Relationship (Blood Relatives Only)
Blindness	·	·	_____
Eye Turn	·	·	_____
Glaucoma	·	·	_____
Macular Degeneration	·	·	_____
Retinal Detachment	·	·	_____

Other: _____

Review of Systems: Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat
- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other

Gastrointestinal
- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

Skin/Integumentary
- None
- Eczema
- Rosacea
- Psoriasis
- Other

Psychiatric
- None
- Depression
- Bi-Polar
- Schizophrenia
- Other

Cardiovascular
- None
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Blood Cholesterol

Endocrine/Glands
- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

Respiratory
- None
- Asthma
- Bronchitis
- Emphysema
- Other

Muscle/Skeletal
- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

Genital/Urinary
- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Hematologic/Lymphatic
- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other

Neurological
- None
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other

General Health
- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Social
- Tobacco Use: Current Smoker Former Smoker
- Non-Prescription Drugs_____
- Alcohol Consumption_____
- Weight_____ Height_____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient (Print): _____ Date:_____

Signature of Patient/ Pt Representative (if patient is a minor or an adult unable to sign this form):_____

Relationship of Patient Representative to Patient: _____

Patient's Name:_____

We offer Visual Field Screening with the use of a highly sophisticated instrument. The Visual Field Analyzer electronically measures retinal function and sensitivity to light. We recommend this procedure for everyone, especially those of us who have headaches, diabetes, high blood pressure, circulatory problems, strong eyeglass prescription, have reached the age of 35, and those who are taking medications.

There is an additional charge of $20.00 for the screening which is not paid by insurance.

_____*YES, I do want the visual field screening.*

_____*NO, I do not want the visual field screening.*

I, the patient , authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to either myself or the party who accepts assignment below. ***HAVING INSURANCE IS NOT A GUARANTEE OF BENEFIT OR PAYMENT.*** *I also realize that if my insurance does not pay, I will be responsible for the services rendered.*

*PATIENT SIGNATURE:*_____*DATE*_____

Insurance Information

Primary Insurance

Insurance Name_____

Main Person Enrolled (Sponsor's Name) _____

(Sponsor's) Date of Birth _____ Employer's Name_____

ID #_____ Group #_____

Patient's Name_____ Relationship to Patient _____

Secondary Insurance

Insurance Name_____

Main Person Enrolled (Sponsor's Name) _____

(Sponsor's) Date of Birth _____ Employer's Name_____

ID #_____ Group #_____

Patient's Name_____ Relationship to Patient _____

Patient/Authorized Person's Signature_____Date_____

Do you have a third insurance? Yes No If yes, please provide information needed to process this claim.