Tammy J. Panner, O.D.
Joanna L. Wen, O.D.
Primary Care and Developmental Optometrists

Welcome to Our Office

Please print this form and complete all fields:

Patient's Name: Mr./Mrs./Ms.____________________________ Today's Date ______________
By what name would you prefer to be called? ____

Address ______________________________________ Home Phone ____________________
City ___________________ State _______ Zip _______ Cell Phone_____________________

Date of Birth ________________ E-mail address _____________________________

Employer _______________________________________ Work Phone___________________
Occupation __________________________ Social Security No. ________________________

(If Student) School ___________________________________ Grade _____________________

Name of Spouse/Parent (if applicable) ____
Spouse/Parent's Employer __________________________ Work phone __________________

How did you first find out about our office?
( )Another patient/Family member (please name) ________________________________
( ) Insurance ( ) Internet ( ) Location ( ) Yellow pages ( ) Other

Major Medical Insurance ____
Do you need a referral from your primary care physician for non-routine care? ( ) Yes ( ) No

Please check method of payment:

( ) Cash ( ) Check ( ) Credit card (Visa, MasterCard, Discover)
(There will be a $30.00 fee for returned checks)
( ) Vision Care Plan (please name) ____

I hereby authorize any necessary medical treatment rendered by Drs. Paquin, Panner or Wen. I understand that payment for such services is expected when services are rendered, and I agree to be responsible for my bill and any collection fees necessary to collect such payment. I also understand that preauthorization of coverage does not guarantee payment by my insurance company, and I agree to assume all financial responsibility for balances not paid by my insurance company within ninety days of submission of claims. I also authorize this office to release any information necessary to expedite my insurance claims.

____ ____________________
Signature of Patient/Parent Date
(If a minor, Parent or Guardian must sign)

Date of last eye exam ___________________
Previous eye doctor and city ____

Have you had: ( ) Glasses ( ) Contact lenses ( ) Refractive surgery (LASIK/PRK)
Are you interested in: ( ) Contact lenses ( ) LASIK/PRK

Do you have trouble seeing:
( ) At night/ with glare ( ) Computer/laptop ( ) Cell phone ( ) GPS ( ) Hobbies/sports

Do you routinely wear eye protection for:
( ) Ultraviolet light (sunglasses) ( ) Sports (sports goggles) ( ) Occupation (safety glasses)

Date of last general health exam ______________ Physician _______________________

Review of Systems
Do **you** have a history of any of the following conditions (common examples in parentheses):

( ) Glaucoma
( ) Cataracts
( ) Eye Disease
( ) Eye Surgery
( ) Eye Injury
( ) Lazy eye
( ) Eye Turn
( ) Double vision

( ) HIV+ or AIDS
( ) Blood disorders (anemia)
( ) Respiratory (asthma)
( ) Constitutional (faint/dizzy)
( ) Psychiatric (depression)
( ) Cardiovascular (high blood pressure, ej qngvtqn+""""""""""""
P qpg"qh"vj g"cdqxg""""""""""""""""""""""""

( ) Skin conditions (rosacea, excema)
( ) Gastrointestinal (Crohn's, colitis)
( ) Genitourinary (kidney, bladder)
( ) Endocrine (diabetes, thyroid)
( ) Neurological (headaches)
( ) Ear/Nose/Throat (sinus/ears)
( ) Musculoskeletal (fibromyalgia, rheumatoid arthritis)

Specifics of above or other medical conditions ______________________________________
____

Are you presently taking any medications (including oral contraceptives)? ( ) Yes ( ) No
If yes, please list which ones and for what purpose.
____
____

Allergic to: ( ) Pollen, molds, dust, etc. ( ) Latex rubber ( ) Medications
What medications? ____

Is there a **family** history of any of the following:
( ) Diabetes ( ) High blood pressure ( ) Heart disease
( ) Glaucoma ( ) Retinal Detachment ( ) Macular Degeneration