

CAROLINA OPTOMETRIC of ARDEN

MICHAEL J SOWA OD FAO

2145 Hendersonville Road Suite D
Arden NC 28704
828/681-8000

Please complete entire form. Thank You!

PATIENT INFORMATION		Name _____		Preferred Name to be Addressed By _____	
Social Security # - -		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered			
Date of Birth / /	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Home Telephone # ()	
Mailing Address		City		State	Zip
Employment Status <input type="checkbox"/> Retired <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Unemployed		Student <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time			
Employer / School Campus		Work Phone # ()		Cell or alternative # ()	
Are you currently enrolled with any major medical and/or vision plan?					YES / NO
If Yes (please circle) BCBS UHC CIGNA CRESENT MEDICARE MEDICAID NCHC EYEMED VSP Other _____					
E-Mail Address:		Pharmacy:		Address:	
RESPONSIBLE PARTY			Who is the Responsible Party? <input type="checkbox"/> Patient (Self) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent		
Name		Home Telephone # ()			
Mailing Address		City		State	Zip
Employer		City		State	Work Telephone # ()
PRIMARY INSURANCE			Insurance Company Name		
Insured Name		ID #		Group #	
Sex	Date of Birth	Relationship to Patient	Employer		

HOW or by WHOM WERE YOU REFERRED TO US ?

EMERGENCY CONTACT		Relationship to patient:	
Name:		Telephone: (Home)	
		(Cell)	

PLEASE PROVIDE YOUR INSURANCE CARD(S) FOR FILING PURPOSES

With my signature, I authorize treatment by Michael J. Sowa, OD and understand I am financially responsible for all charges for services rendered, including the balance remaining after possible insurance benefits. I authorize release of any medical information necessary to process my insurance claim(s) or the sending of any necessary information to another physician. I assign and request insurance payments be made directly to Carolina Optometric of Arden, PA.

Signature _____ (Required) _____ (Today's Date)

UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE PAYMENT IS EXPECTED UPON CHECK-OUT

* PLEASE COMPLETE OTHER SIDE*



CONFIDENTIAL MEDICAL / OPTICAL HISTORY

Please complete entire form. Thank You!

List EYE PROBLEMS You Are Having: _____

Do You Wear GLASSES ? : Single Vision Bi-Focal No Line Progressive Polarized Prescription Glasses Readers

Do You Wear CONTACTS? : Daily Wear Extended Wear Soft Disposable Rigid Gas Perm Brand? _____

List Any Eye Surgery or Injuries: _____

List Major Illnesses or Operations: _____

List ALL MEDICATIONS You Are On: None 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____ Any EYE DROPS ? _____

List Any ALLERGIES TO MEDICATION: None, or _____

Your General Physician: _____ Your Last Eye Doctor: _____ Your Last Eye Exam Date: _____

MEDICAL AND SOCIAL HISTORY	(Circle Yes or No – Please answer all)
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(Month and Year)

	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Cardiovascular Problems	Yes	No
Hearing Loss/Problems	Yes	No
Macular Degeneration	Yes	No
Retinal Disease	Yes	No
Glaucoma	Yes	No
Allergies	Yes	No
Psychiatric Problems	Yes	No
Immunologic Problems	Yes	No
Genitourinary Problems	Yes	No
Hormonal/Endocrine Problems	Yes	No
Hematological Problems	Yes	No
Sexually Transmitted Disease(s)	Yes	No
Asthma	Yes	No
Hepatitis	Yes	No

	Yes	No
Respiratory Problems	Yes	No
Musculoskeletal Problems	Yes	No
Gastrointestinal Problems	Yes	No
Lymphatic Problems	Yes	No
Thyroid Problems	Yes	No
Cancer	Yes	No
Neurological Problems	Yes	No
Ear-Nose-Throat Problems	Yes	No
Renal / Kidney Stones	Yes	No
Alcohol Use	Yes	No
Nicotine Use	Yes	No
Drug Use	Yes	No
Computer Use	Yes	No
Do You Live Alone?	Yes	No
Are You Pregnant?	Yes	No
Are You in Good Health Today?	Yes	No

Briefly Explain Above Problems: _____

List Your FAMILY'S MEDICAL AND EYE PROBLEMS: (Both MEDICAL and OCULAR): _____

Clinical Vision Evaluation Form

To provide you with the best vision possible, we need to know a little more about you. Please fill in the blanks below. Thanks !

Briefly describe your OCCUPATION, HOBBIES, and SPORT ACTIVITIES: _____

Do you spend your time? Reading (Hours/Day _____) Computer(Hours/Day _____) Long Distance Driving Outdoors

If you currently wear glasses, what would you change about them? _____

Are your eyes sensitive to sunlight? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear sunglasses ? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you interested in corrective surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	If you wear contacts, any trouble with dryness or comfort? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you interested in wearing contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you planning to get new glasses today ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Only if needed
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I verify that the above information is correct to the best of my knowledge.
 I have been offered a copy of the **Notice of Privacy Practices** for me to read, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. If I requested a copy of the Notice of Privacy Practices, this notice provided to me.

Patient Signature (REQUIRED)	Today's Date	Michael J. Sowa, OD, FAAO (Reviewed by Physician)
Relationship to Patient, if not signed by patient: _____		