OSWEGO Optique
A MEMBER OF VISION SOURCE

Dr. Stephen Olsen
Dr. Shari Mace
Dr. Scott Cooper
Optometrists

Welcome To Our Office

Name:		**Date:**
Address:	**City, State, Zip:**	
Primary Phone: ☐ Mobile	**Other Phone:** ☐ Mobile	**Email:**
Date of Birth:	**Social Security#** (Last 4 digits only):	**Communication Preference:** ☐ Phone ☐ Email ☐ Text ☐ Postal
Employer:	**Occupation:**	
Work Phone: ☐ Mobile	**Height:**	**Weight:**

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to share

Race: ☐ Caucasian ☐ Black/African American ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other _____

Insurance Information

Medical Insurance Company Name:			**Vision Insurance Company Name:**	
ID#:	**Group#:**		**ID#:**	**Group#:**
Primary Subscriber (if different from patient):			**Primary Subscriber (if different from patient):**	
Relationship: ☐ **Spouse** ☐ **Parent** ☐ **Other**			**Relationship:** ☐ **Spouse** ☐ **Parent** ☐ **Other**	

I, the undersigned, have insurance coverage with _____and assign directly to Dr. _____ all medical and/or vision benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature: _____ **Date:** _____

(Please turn over and complete other side)

Medical and Visual History

Please circle/indicate all that apply:

Diabetes:	Self	Mother	Father	Other family:_____
High Blood Pressure:	Self	Mother	Father	Other family:_____
High Cholesterol:	Self	Mother	Father	Other family:_____
Cataracts:	Self	Mother	Father	Other family:_____
Glaucoma:	Self	Mother	Father	Other family:_____
Macular Degeneration:	Self	Mother	Father	Other family:_____
Thyroid:	Self	Mother	Father	Other family:_____
Cancer:	Self	Mother	Father	Other family:_____
Asthma:	Self	Mother	Father	Other family:_____

Allergies: To medications:_____ Other:_____

Eye surgery: Cataract Lasik PRK RK Other_____

Frequent Headaches? Yes / No If yes, please describe:_____

Do you smoke? Yes / No

Pregnant/Nursing? Yes / No

Current prescription medications:_____

_____

Current over-the-counter medications:_____

_____

Date of last vision exam:_____ **Examining Doctor:**_____ **(If other than here)**

Currently wear glasses? ☐Full time ☐Part time		**For:** ☐ Distance ☐ Near ☐ Both	
Wear contact lenses? ☐Full time ☐Part time		**For:** ☐ Distance ☐ Near ☐ Both	
	☐ Soft ☐ Toric ☐ Bifocal ☐ Rigid ☐ Disposable	☐ Daily Wear ☐ Extended Wear	
	Daily wearing time:	Replacement Schedule:	Disinfection Solution:

Any special visual tasks (computer, sports, outdoors, etc.):_____

Reason for today's appointment:_____

Who may we thank for referring you?_____