WELCOME TO OUR OFFICE

Thomas M. Kelly, O.D., Inc.

Carrie L. Trigilio, O.D.

(Please Print)

Name_____Spouse or Parent Name _____

Street_____ City_____ Zip_____

Phone_____Email_____ Birthdate_____ Age_____ Sex_____

Soc.Sec.No._____ Employer/School_____ Occupation/Grade_____

Hobbies/Sports_____ Who may we thank for referring you? _____

May we contact you by text? YES NO Number for texting_____

WHAT IS THE MAJOR REASON FOR THIS EXAM? _____

_____

Family Medical History

Blindness	No	Yes_____
Cataracts	No	Yes_____
Glaucoma	No	Yes_____
Diabetes	No	Yes_____
Heart Disease	No	Yes_____
Macular Degeneration	No	Yes_____
Other_____		

Personal Medical History

Allergies	Y	N	Arthritis	Y	N
Asthma	Y	N	Cancer	Y	N
Headaches	Y	N	Diabetes	Y	N
Eye Surgery	Y	N	Hypertension	Y	N
Kidney Disease	Y	N	Eye Injury	Y	N
Cataracts	Y	N	Lazy Eye	Y	N
Thyroid	Y	N	Double Vision	Y	N
Neurological	Y	N	Heart Disease	Y	N

Have you ever worn contact lenses?	Y	N
Are you interested in contacts?	Y	N
Are you interested in Laser Correction?	Y	N
Do your eyes frequently itch or burn?	Y	N
Do you:		
-work on a computer for long periods?	Y	N
-have more than one pair of glasses?	Y	N
-want thinner, lighter lenses?	Y	N
-wear bifocals?	Y	N
-if yes, are you bothered by bifocals?	Y	N
- always wear glasses?	Y	N
- have prescription sunglasses?	Y	N
- have problems with glare or reflection?	Y	N

How will you settle your account today?

Check ___Credit Card___ Ins.___ Insured DOB_____

Parent accompanying minor is responsible for payment. Payment is expected when services are rendered unless other arrangements are made in advance

Current Medications

Please list all medications you are currently taking, both Rx and over the counter. _____

_____

_____

Do you use tobacco products? Y N

Do you use alcohol? Y N

Medical Insurance _____

Vision Insurance _____

Name of Physician _____

I authorize use of this form on all my insurance submission.
I authorize release of information to all my insurance companies.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I understand that I am responsible for my bill.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
I acknowledge that I received a copy of the notice of privacy practices that describes how my medical information may be used.

Signature _____

Date_____