ALEXANDER EYE ASSOCIATES
ALEXANDER OPTICAL
261 Alexander Street • Rochester, NY • 14607
(585) 325-3070

PLEASE PRINT

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PATIENT INFORMATION

Name: _____ ☐Miss ☐Ms. ☐Mr. ☐Rev. ☐Mrs. ☐Sr. ☐Dr. ☐Other:____
First Name Middle Initial Last Name

Preferred Name/Nickname: _____ Date of Birth: _____

Address: _____ Sex: ☐ Male ☐ Female

City/State/Zip: _____ Pronouns: _____

Phone: H) _____ W) _____ C) _____

EMPLOYER / OCCUPATION: _____

E-mail: _____

SPOUSE / PARTNER: _____

CONTACT PERSON

Name: _____ E-mail: _____
First Name Middle Initial Last Name
(Guardian - if patient is under age 18 yrs of age)

Address: _____ Relationship to patient: _____

City/State/Zip: _____

Phone: H) _____ W) _____ C) _____

FINANCIAL ASSIGNMENT

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable

_____
Initial agreeing to above terms

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Notice of Privacy Practices from Dr.'s Caito & Sugnet - Alexander Eye Associates - Alexander Optical

I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices

☐ **Yes, I have read or had explained to me by this office the NPP & wish to continue my care under said terms.**

☐ **No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.**

☐ **The NPP could not be read due to the emergent nature of the care needed.**

_____ _____
Signature agreeing to all above terms Date

(Please turn over for p. 2)

Name: _____ DOB: _____

Vision and Medical History

When (approx.) was your **last eye exam**? _____Where: _____

Do you: ☐ wear glasses? ☐ wear contact lenses? ☐ have never worn glasses or contacts

What brings you in? _____

Primary Care MD: _____

Specialist (Neurologist, Endocrinologist, Rheumatologist, etc.): _____

Do you have any of the following:

- ☐ Cancer
- ☐ HIV / AIDS
- ☐ Dry Mouth
- ☐ Multiple Sclerosis (MS)
- ☐ Epilepsy
- ☐ Migraines/headaches
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Hypertension (High Blood Pressure)
- ☐ Stroke/CVA
- ☐ Heart Disease/Congestive Heart Failure
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Arthritis/Osteoarthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Rosacea
- ☐ Herpes Simplex / Cold Sores
- ☐ Diabetes: ☐ Type 1 ☐ Type 2
- ☐ Thyroid Dysfunction
- ☐ High Cholesterol
- ☐ Strabismus (Crossed eyes)
- ☐ Amblyopia (Lazy Eye)
- ☐ Floaters or spots
- ☐ Dry eyes – sandy, gritty feeling in eyes
- ☐ Loss of vision
- ☐ Tired eyes
- ☐ Watery eyes

☐ Other Medical Conditions/Surgeries:

_____

_____

☐ Other eye conditions/surgeries: _____

☐ Allergies: _____

Please list all prescription and non-prescription drugs you are currently taking:

_____

_____

Do you drink alcohol? ☐ No ☐ Yes

Have you ever smoked? ☐ No ☐ Yes ☐ Cigarettes ☐ Marijuana ☐ Cigar ☐ Pipe

If Yes: #cigarettes/day_____ #yrs_____

If applicable, when did you quit smoking? _____

Family History

Do any family members (blood relatives) have or had:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Eye turn / Amblyopia / Lazy Eye
- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Blindness

?

Do you have any Hobbies?

Referral

How did you find us?

- ☐ Referred by Healthcare Professional: _____
- ☐ Referred by a current patient: _____
- ☐ Internet search ☐ Visited our Website ☐ Found us on social media ☐ Phone Book

Questions

Do you have a question? Concerns? We want to know!