Dr. Slaugh, Pedersen & Associates

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We welcome you to our practice, thank you for choosing us! Please take a moment to complete this form.

Patient Name: ____ M__ F___ DOB: ________________ SSN: _____________________

Address: ____ City: ____________________________ State: ______ Zip: _______

Responsible Party Name: ____ Mother / Father Same Address? Y / N

Home Ph: ____-____-______Work Ph: ____-____-______Cell: ____-____-______ Text? Y / N **E MAIL**:__________________________________

Insurance Provider: ____

Subscriber Primary Insured Name: ______________________________________ Subscriber DOB: ____________Subscriber SSN: _____________

Married______ Single________ Other_________ Pharmacy you Prefer to use:________________________City:________________________

Who may we thank for referring you to our practice? ____

Family Doctor: ________________________ How can we help you see better today?____

_______ (initials) Contact lenses require additional testing and evaluation, thus there is an additional fee for our contact lens patients. Our fee for these services ranges from **$55 to $105**. We will notify you of your exact fee before we provide this service. You have 6 weeks to finalize Contact lens prescription included in this fee.

ALL FEES INCLUDING INSURANCE COPAYS ARE DUE AT TIME OF SERVICE:______________ (INITIALS)

Please list all of your current medications: ____

Medication allergies? Y / N If yes, please specify: ____

The following pertains to your visual symptoms and health history. Please check all that apply.

SEIZURE DISORDER YES_____ NO_____ Hepatitis: _____Yes Type:____None:_____ HIV: Yes: _____ None:_______

Height: _______ Weight: _________
# of hours spent daily on a computer:______

VISION With RX:___ No RX :___
- ☐ Distance vision blurred
- ☐ Near vision blurred
- ☐ Teary/watery eyes
- ☐ Itchy eyes
- ☐ Burning eyes
- ☐ Dry eyes
- ☐ Double vision
- ☐ See flashing lights
- ☐ Floaters or spots
- ☐ Macular degeneration ☐ In family
- ☐ Glaucoma

IMMUNOLOGIC ☐ None
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Other

CONSTITUTIONAL ☐ None
- ☐ Weight loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Other

HEMATOLOGIC ☐ None
- ☐ Anemia
- ☐ Leukemia
- ☐ Other

MUSCULOSKELETAL ☐ None
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis

RESPIRATORY ☐ None
- ☐ Cigarette smoker
- ☐ Asthma
- ☐ Emphysema
- ☐ Other

CARDIOVASCULAR ☐ None
- ☐ Diabetes
- ☐ Hypertension
- ☐ Vascular disease
- ☐ Other

EAR, NOSE AND THROAT ☐ None
- ☐ Respiratory tract infection
- ☐ Meds
- ☐ Other

GASTROINTESTINAL ☐ None
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Other

PSYCHIATRIC ☐ None
- ☐ Depression
- ☐ Schizophrenia
- ☐ Other

_______ (initials) I understand that the benefits quoted to me are not a guarantee of payment and that I am responsible for all of my out of pocket expenses at the time of service. I understand that payment by my insurance company is based on my eligibility and coverage at the time services are rendered. I authorize payment by my insurance directly to *Russell R. Slaugh, O.D., an Optometric Corporation.*

The undersigned patient hereby authorizes Russell R. Slaugh, O.D. and associates to use or disclose the patient's PHI to carry out treatment, payment or health care operations on behalf of the patient.) I understand the "Notice of Privacy Practices" HIPAA agreement and have been offered a copy of it.

Patient Signature: ____ Date: ____________________________

FOR OFFICE USE ONLY - REVIEWED BY DOCTOR

Initials ___________ Date_____________ Initials ___________ Date_____________ Initials ___________ Date_____________