Dr. Gottlieb
OPTOMETRY

Laser Vision Consultation * Vision Health Exams * Eyeglasses * Contact Lenses

Date ___/___/_____ ☐ Previous Patient ☐ New Patient; Referred by: _____

☐ Dr.
☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss

Last Name | First name and nickname | Middle Initial

Street Address | City | State | Zip Code

___/___/___ Date of Birth | Last 4 of Social Security (Requested if using insurance) | Vision Carrier | Cell Phone ( ) | Home / Work Phone ( )

Preferred Contact Method: ☐ Text ☐ E-mail

E-mail Address _____ Medical Carrier (HMO / PPO): _____

Please note: In order to maintain our low fees we must adopt the following office polices. We cannot be responsible for delays due to lab breakage and/or manufacturer's backorders. Orders cancelled during lab processing will be charged a 25% handling fee. Orders not picked up within 60 days of completion will forfeit their deposit. A $30 fee will be applied to all frames that need to be restocked. All returned checks will incur a $25 fee and may be liable for 3x the written amount.

Signing this document signifies that you agree with the above office policies.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office.
The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.
I acknowledge that I have received the *Notice of Privacy Practices* from Larry J. Gottlieb, O.D. A Professional Corp.

_____ _____
Signature | Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Source of Authority / Relationship to Patient | Print Name

Dr. Gottlieb recommends Optomap retinal imaging screening to:

- Allows us to screen for diseases like: diabetes, hypertension and high cholesterol
- A much quicker test to complete vs dilation
- No light-sensitivity and blur for hours afterwards
- Creates a permanent record which allows for side by side comparisons, helpful in tracking glaucoma and macular degeneration

Optomap is only $35 for patients ages 35+, or just $20 for our younger patients. In most cases this is not covered by insurance.

☐ Yes, I would like Optos reviewed today ☐ Unsure, I would like to discuss with the doctor

Today, you would like: ☐ New Eyewear ☐ New Contacts ☐ Information on LASIK ☐ Corneal Reshaping Lenses
Occupation _____
Computer usage: ☐ Desktop\☐ Laptop\☐ Cell/Tablet
Hours of usage/day: _______________
Last Eye Exam: _____ Where? _____
Last Physical: _____ Physician/City? _____
Height: _____ Weight: _____
Medication Allergies: _____
Double vision: Y ☐ N ☐ Frequency _____ x / Week
Headaches: Y ☐ N ☐ Frequency _____ x / Week
Location: front
What helps them? nothing
Allergies: Y ☐ N ☐
Dry eye: Y ☐ N ☐
Any Ocular involvement? If yes, check symptoms below:
☐ Itchiness ☐ Tearing
☐ Redness ☐ Swollen Lids
Any history of Eye Infections?: Y ◯ N ◯
Describe: _____
Any Discomfort on Eye Movements?: Y ◯ N ◯
Describe: _____
Any prior Eye Injuries/Surgeries?: Y ◯ N ◯
Describe: _____
Any reported tobacco use?: Y ◯ N ◯ -> *If yes, how many packs a day?* _____

List any medications or drugs or supplements taken:
(Both Prescription & Over-the-Counter, including any eye drops)

1	4
2	5
3	6

What activities/hobbies do you regularly participate in?:

1	4
2	5
3	6

Family History / Personal History:		Self	Maternal	Paternal
Arthritis / Autoimmune Diseases		☐	☐	☐
Asthma/COPD		☐	☐	☐
Cancer	Type(s):_____	☐	☐	☐
Thyroid	Type: _____	☐	☐	☐
Diabetes	Type: _____	☐	☐	☐
Glaucoma	Type(s):_____	☐	☐	☐
Heart Disease		☐	☐	☐
High Blood Pressure	Type: _____	☐	☐	☐
High Cholesterol		☐	☐	☐