Watts optical

& Eye Care Center

2914 Hawkins Drive • Searcy, AR 72143 • (501) 268-3596

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form. If you have any questions we will be glad to help you.

PATIENT INFORMATION

DATE: ______________________

Patient Last Name: ______________ First Name: ______________ Middle Name: ______________

Social Security #: ______________ Sex: Male ___ Female ___ Age: ______ Date of Birth: ______________

Mailing Address: ______________ City: ______________ State: ______ Zip: ______________

Primary Phone #: ______________ Secondary Phone #: ______________ Work Phone #: ______________

Employer/Job Title: ______________ Spouse: ______________

E-Mail: ______________

IMPORTANT! If the patient is under 18 years of age, we require information on the person who has legal responsibility [even if the minor has insurance].

What is the RESPONSIBLE parent or guardian's Last Name: ______________ First Name: ______________ Middle Name: ______________

Street Address: ______________ City: ______________ State: ______ Zip: ______________

Primary Phone #: ______________ Secondary Phone #: ______________

EMERGENCY CONTACT INFORMATION

In Case of an Emergency, Contact (Specify someone who does not live in your household)

Name: ______________ Relationship: ______________

Primary Phone #: ______________ Secondary Phone #: ______________

MEDICAL INSURANCE INFORMATION

Name of Insurance (OR PROVIDE YOUR ID CARD): ______________

ID # (OR PROVIDE YOUR ID CARD): ______________

VISION INSURANCE INFORMATION

Name of Insurance (OR PROVIDE YOUR ID CARD): ______________

ID # (OR PROVIDE YOUR ID CARD): ______________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________ insurance company and assign directly to Dr. Cecil Watts all insurance 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 authorize the use of my signature on all insurance submissions.

The above-name doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent or Guardian: ______________ Date: ______________

Please print name of Patient, Parent or Guardian: ______________

OVER

HEALTH INFORMATION DISCLOSURE

I authorize the release of pertinent information to the following individuals:

Name:______________________ Relationship:______________________ Phone#:______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

MEDICATIONS

List any medications you are currently taking, including eye drops: (OR PROVIDE A LIST)

____

____

ALLERGIES

List your allergies to medications or other substances:

____

____

PHARMACY INFORMATION

Pharmacy Name:______________________________ Phone #:______________________

EYE COMPLAINT

Blood Shot Eyes	Yes___	No___	Dry Eyes	Yes___	No___	Loss of Vision	Yes___	No___
Blurred Vision-Distance	Yes___	No___	Eye Allergies	Yes___	No___	Migraine Headaches	Yes___	No___
Blurred Vision-Near	Yes___	No___	Eye Infection	Yes___	No___	Need Glasses or Contacts	Yes___	No___
Burning Eyes	Yes___	No___	Eye Injury	Yes___	No___	Night Vision, Poor	Yes___	No___
Cataracts	Yes___	No___	Eye Strain	Yes___	No___	Pain or Discomfort	Yes___	No___
Color Vision, Poor	Yes___	No___	Fainting Spells, Blackouts	Yes___	No___	Red Eyes	Yes___	No___
Contact Lens Discomfort	Yes___	No___	Floaters or Spots	Yes___	No___	Seeing Halos	Yes___	No___
Contact Lens	Yes___	No___	Glaucoma	Yes___	No___	Seeing Flashes	Yes___	No___
Crossed Eyes	Yes___	No___	Growth in or around eye	Yes___	No___	Temporary Loss of Vision	Yes___	No___
Discharge from Eyes	Yes___	No___	Headaches	Yes___	No___	Twitching Eyelid	Yes___	No___
Dizzy Spells	Yes___	No___	Itching Eyes	Yes___	No___	Watering Eyes	Yes___	No___
Doctor Directed Visit	Yes___	No___	Lids Stuck/Upon Waking	Yes___	No___	Other______________________		
Double Vision	Yes___	No___	Light Sensitive	Yes___	No___			

HEALTH HISTORY

(PCP) Physician ______________________________ Date of Last Visit:______________________

	Yourself	Family	Relationship		Yourself	Family	Relationship
Aids/Hiv	Yes___No___	Yes___No___	____________	Kidney Disease	Yes___No___	Yes___No___	____________
Arthritis	Yes___No___	Yes___No___	____________	Lazy Eye	Yes___No___	Yes___No___	____________
Artifical Eye	Yes___No___	Yes___No___	____________	Lupus	Yes___No___	Yes___No___	____________
Asthma	Yes___No___	Yes___No___	____________	Macular Degeneration	Yes___No___	Yes___No___	____________
Blindness	Yes___No___	Yes___No___	____________	Migraine Headaches	Yes___No___	Yes___No___	____________
Cancer	Yes___No___	Yes___No___	____________	Pacemaker	Yes___No___	Yes___No___	____________
Cataracts	Yes___No___	Yes___No___	____________	Poor Color Vision	Yes___No___	Yes___No___	____________
Chemical Dependency	Yes___No___	Yes___No___	____________	Retinal Disease	Yes___No___	Yes___No___	____________
Diabetes	Yes___No___	Yes___No___	____________	Rheumatic Fever	Yes___No___	Yes___No___	____________
Drug Sensitivity	Yes___No___	Yes___No___	____________	Shingles	Yes___No___	Yes___No___	____________
Emphysema	Yes___No___	Yes___No___	____________	Skin Conditions	Yes___No___	Yes___No___	____________
Epilepsy	Yes___No___	Yes___No___	____________	Stroke	Yes___No___	Yes___No___	____________
Eye Surgery	Yes___No___	Yes___No___	____________	Thyroid Conditions	Yes___No___	Yes___No___	____________
Fibromyalgia	Yes___No___	Yes___No___	____________	Tuberculosis	Yes___No___	Yes___No___	____________
Glaucoma	Yes___No___	Yes___No___	____________	Turned Eye	Yes___No___	Yes___No___	____________
Hay Fever	Yes___No___	Yes___No___	____________	Tobacco use?	Yes___No___		
Heart Condition	Yes___No___	Yes___No___	____________	Alcohol use?	Yes___No___		
Hepatitis (Type__________)	Yes___No___	Yes___No___	____________	(Women) are you pregnant?	Yes___No___		
High Blood Pressure	Yes___No___	Yes___No___	____________				

NEW PATIENT INFORMATION

(Complete this section if you have not been examined by Dr. Watts before today/or if you have seen another optometrist since your last visit)

Previous Eye Doctor: ______________________ Date of last eye exam: ______________________

Do you wear glasses? Yes___ No___ All the time___ Occasionally___ Reading___ Driving___ Watching TV___

Do you wear Contact Lenses? Yes___ No___ Brand/Type ______________________ Hours per Day__________

Describe any problems you have with your contact lenses ______________________________