Welcome to Oakbrook Optometry office of:
Dr. Paul Snyder, O.D.
(Please print)

Patient Information

Patient's Name____ Date__________________ First Visit? □Yes □No

Gender: □Male □Female Age ______ Date of Birth___________________________

Preferred Language:__________________ Race:____________________ Ethnicity:_______________________

How did you choose our office?____

Address________________________________ City___________________ State_____ Zip________________

Home Phone (_____)______________ Cell Phone (_____)__________________Work Phone (_____)______________

Email address:__________________________ Type of communication preferred: Text Email Cell Home

Place of Employment_______________________________ Occupation________________________________

What hobbies, sports or leisure activities you enjoy?____

Other immediate family members who are patients here?____

Medical/Eye Health History

Reason for today's visit: ☐ New Glasses ☐New Contacts ☐CRT ☐Other:__________________________

Primary Physician's Name____________________ Major Medical Ins.___________________________ PPO/HMO?

Date of last eye exam_________________________ From Dr.______________________________________

Have you ever had your eyes dilated? ☐Yes ☐No When?____

Are you taking any medications? ☐Yes ☐No List:____

Please check any of the following conditions that you have experienced:

□ Blurry Vision □ Cataracts □ Eye Surgery
□ Double Vision □ Glaucoma □ Detached Retina
□ See Spots □ Eye Injury □ Dry Eyes
□ Eyelid Problems Other:____

Please check any of the following conditions that apply to you:

□ Heart Disease □ Diabetes □ Lung Disease □ HIV positive
□ High Blood Pressure □ Cancer □ Kidney Disease □ Elevated cholesterol
□ Auto Immune Disease □ Ulcer □ Thyroid Disease □ Stroke
□ Sinus Problems □ Headaches □ Other:____

Do your blood relatives have any of the above conditions? □ Yes □ No Explain:_____________________________

Do you have trouble reading signs when driving at night? □ Yes □ No
Have you noticed you are more sensitive in bright sunlight? □ Yes □ No
Do you currently use sunwear for daytime driving? □Yes □ No
How many hours a day are on the computer?______________

Are you pregnant? □ Yes □ No
Have you ever worn contact lenses? □ Yes □ No
Do you drink alcohol? □ Yes □ No How often?___________
Have you ever used tobacco products □ Yes□ No How long?

Are you interested in laser refraction surgery? □ Yes □ No
Interested in wearing contact lenses? □ Yes □ No
Do you use recreational drugs? □ Yes □ No
Do you currently use tobacco products? □ Yes □ No

Insurance Information

Name of insured________________________________ Relationship to Patient ___________________

Birth Date __________________________ Social Security Number ____________________________

Name of Employer ____________________________________ Work Phone (____)____________________________

Insurance Company ____________________________________ Group Number ______________________________

Do you have additional vision insurance? □ No □ Yes Name of Insurance_____________________________________

May we leave personal medical information on your home answering machine? YES NO
May we discuss your medical information with family members/ primary physician? YES NO
If yes, please provide their names and phone numbers below.

Name: ________________________**Relationship:**___________________________

Name: ________________________**Relationship:**___________________________

Policies: No out of state checks. No two party checks. No traveler's checks. Checks must have a pre-printed address. Must have a valid picture ID to match address on check, Military ID, or school ID with valid SSN card. There will be a $15.00 service charge on all returned checks. A service charge of 1 ½ % per month (18% per annum) will be added on all balances over 30 days past due. In the event it becomes necessary to collect fees through litigation the patient agrees to pay all court costs, deposition fees, and reasonable attorney's fees incurred. We report all bad checks to the district attorney's office.

Authorization

I certify that I have read and understand the above information to the best of my knowledge. I have answered the questions accurately and understand that providing incorrect information can be hazardous to my health. I authorize the eye doctor to release any information including the diagnosis, records of treatment, and examination rendered to me or my child during the period of such eye care to third party payers and health practitioners. I authorized and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my insurance may pay less than the actual bill for services and will take the responsibility for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent if a minor) Date