Netra Optometric Associates
4203 W. Wendover Ave Suite F
Greensboro, NC 27407

Patient's Information

Today's Date: ___________________ Sex: M / F

Name: ____ Date of Birth: ________________________

Address____

City____ State/Zip____________________

☐ Cell Phone__________________________________ Email:____________________________________

Reason for Visit: ☐ Routine Eye Exam ☐ Diabetic Eye Exam ☐ Contact Lens Exam ☐ Other: _______

Parent/Legal Guardian's Information

Name: ____ Date of Birth: _____________________________

Relationship to minor: _____________________________ Phone:____________________________________

Address:____

In most cases minors have to be dilated, please indicate if you DO NOT want your child to be dilated ☐ **Dilation declined**

Insurance Information (We do NOT accept checks)

☐ Self Pay ☐ Vision Plan::________________________ Policy#:____________________________________

Policy Holder's Name:______________________________________ Relationship:________________________

Last 4 digits of primary member Social Security #__________________ DOB:_____________________________

Medical insurance:_________________________________ Policy#:____________________________________

Policy Holder's Name/DOB: ______________________________________ Relationship:____________________

Payment and/or co-pay amounts are due at the end of service. Professional services are nonrefundable.

Medical Release Authorization

I __________________________________ authorize the release of information including diagnosis, records, billing/claims and prescription rendered to me to:

Name of person/business to share information with ______________________ **Relationship** ______________________

Name of person/business to share information with ______________________ **Relationship** ______________________

☐ **Information is not to be released to anyone.**

***This release of information will remain in effect until terminated by me in writing.**

Please review our office policies and HIPPA information. You will be asked to sign electronically by the end of service.
Thank you for choosing Netra Optometric for your eye care needs.

Eye Conditions

Last Eye Exam: ________________ Previous Eye Doctor: ______________________________________

Do you currently wear contact lenses? If so, what brand? ____

- Blurry Vision ❑ Eye Pain ❑ Double Vision ❑ Excess Tearing ❑ Burning ❑ Floaters
- Vision Loss ❑ Sties ❑ Burning ❑ Light Sensitivity ❑ Itching ❑ Retinal Detachment
- Cataracts ❑ Flashes ❑ Glaucoma ❑ Redness ❑ Dryness ❑ Macular Degeneration

Patient Medical History

Primary Care Physician: __________________________Phone #: ___________________________

Please check all that apply to you.

Constitutional

❑ Cancer

Type/Duration:______________

❑ Fatigue Syndrome

❑ Developmental Disabilities

Ear/Nose/Throat

❑ Hearing Loss ❑ Laryngitis

❑ Sinusitis❑ Dry Mouth

Neurologic

❑ Mult. Sclerosis ❑Stroke

❑ Cerebral Palsy ❑Migraines

❑Tumor ❑Autism❑Epilepsy

Psychiatric

❑Depression❑Anxiety

❑Attention Deficit

Cardiovascular

❑ High Blood Pressure ❑Heart Disease

❑Vascular Disease ❑Congestive Heart Failure

Respiratory

❑ Asthma ❑Bronchitis ❑Sleep Apnea

❑ Emphysema❑Chronic obstruction

Gastrointestinal

❑ Acid Reflux ❑Crohn's Disease

❑ Colitis ❑Ulcer

Genitourinary

❑ Kidney Problems ❑Prostate Disease❑STD

❑Herpes/Chlamydia ❑Pregnant ❑ Nursing

Musculoskeletal

❑ Arthritis ❑Osteoarthritis ❑Fibromyalgia

❑Muscular Dystrophy ❑Ankylosing Spondylitis

Integumentary (Skin)

❑Eczema ❑Psoriasis ❑Rosacea

❑Herpes Simplex❑Shingles

Endocrine

❑Thyroid ❑Hormonal Disorders

❑ Type 2 Diabetes ❑Type 1 Diabetes

If yes for diabetes:

Last a1c: ____________________

Fasting B.S. ____________________

Duration: ____________________

Hematologic/Lymph

❑Anemia ❑High Cholesterol ❑Ulcer

Allergic/Immune

❑Drug Allergies ❑Environmental Allergies❑Bipolar

❑Rheumatoid Arthritis ❑Lupus❑Sjogren's

❑**OTHER:** ____

Previous Surgeries/Injuries: ____

SOCIAL

❑Never Smoker ❑ Former Smoker ❑ Current Cigarette Smoker ❑ Other:______________________________

❑Does not drink alcohol ❑ Drinks alcohol- Frequency ______________________________

ALLERGIES ❑Medication Allergies ______________________________________

❑Others____

MEDICATIONS____

____

FAMILY HISTORY - Initial (F) Father; (M) Mother; (B) Brother; (S) Sister; (D) Daughter and/or (SO) Son

❑Arthritis ____________________________

❑Diabetes ____________________________

❑Cancer ____________________________

❑Hypertension ____________________

❑Thyroid Dysfunction ________________________

❑ Macular Degeneration ______________________

❑Cataract ____________________________

❑Glaucoma ____________________________