Welcome to the office of Dr. Hendrik Krosschell, Doctor of Optometry

Name: _____ Date of Birth_____
Address:_____ City_____ State: _____
Zip: _____ Phone: (home)_____(work) _____ (cell)_____
Employer: _____ Occupation:_____
Medical Insurance _____
Vision Insurance _____
Subscriber_____ Subscriber ID or SSI_____
Patient's relation to subscriber: Self Spouse Child Former Spouse Other
email:_____
Referred by: _____

Assignment and Release

I authorize payment of benefits directly to Dr. Hendrik Krosschell for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain that approval, I am financially liable for the services. I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductibles & Fees not paid by my insurance carrier will be my responsibility.
I acknowledge that I received a copy of Dr. Hendrik Krosschell's "NOTICE OF PRIVACY, HIPAA" policy.

Signature_____ Date_____

Medical History Questionnaire

What problems are you currently having with your eyes? Circle all that apply:

Blurred Vision	Redness	Mucous discharge
Distorted vision/halos	Burning	Foreign Body sensation
Loss of side vision	Itching	Sandy or gritty feeling
Loss of central vision	Dryness	Chronic lid infection
Double vision	Tired eyes	Glare/light sensitivity
Flashes/floating spots	Watering Excessively	Eye pain or soreness
Crusting on eyelashes	Having problem with contact lenses?	

Other: _____

Do you have any of the following eye conditions? Circle all that apply:

Blindness	Diabetic Eye Disease	Macular Degeneration
Cross-Eyes	Retinal Detachment	Glaucoma
Cataracts	Lazy Eye	Retinal Disease

Do any blood relatives have any of the following eye or medical conditions? Circle all that apply:

Blindness	Glaucoma	Diabetic eye disease
Cataracts	Macular degeneration	Amblyopia (lazy eye)
Crossed Eye	Diabetes	High Blood Pressure
Cancer	Thyroid Disease	Retinal Disease
Retinal Detachment		

Other: _____

Do you have any of the following medical conditions? Circle all that apply:

Headaches	Allergies/hay fever	Asthma
Diabetes	Migraine	Sinus congestion
Chronic bronchitis	Heart /chest pain	Bleeding disorder
Runny nose	Emphysema	High blood pressure
Stroke/seizures	Cancer	Fever, weight loss/gain
Chronic cough	Arthritis	High Cholesterol
Thyroid disease	Diarrhea/constipation	Dry throat/mouth
Fibromyalgia	Psoriasis or Rosacea	Kidney/bladder disease
Lupus	Depression	Heart Disease

Other: _____

Please answer the following: Circle Answer:

Do you drive? Yes No

Do you consume alcohol? Yes No

Do you use tobacco products? Yes No

Are you a carrier of, or infected with: Hepatitis HIV Gonorrhea/Syphilis None

Marital/Living status: single married widowed living alone live with family or friends.

*****Please list below all medications you are currently taking:*****

_____

_____

When was your last physical exam? _____

Who is your primary care physician? _____

Are you Pregnant? Yes No

Are you allergic to any medications? Yes No (please list) _____

List all major surgeries or injuries you have had in past 10 years._____

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

Do you want to wear contact lenses? Yes No

Are you interested in LASIK or any other vision correction procedures? Yes No