Welcome to Mountain Eye Care - Dr. Jon Zissman, Optometrist

Date_____ Last Name_____ First Name_____ MI_____
Preferred Name_____ Mailing Address (City, State, Zip)_____
Date of Birth_____ Marital Status_____ Occupation_____ Gender_____ SSN_____
Race/Ethnicity _____ Preferred Phone#_____ E-mail Address_____

Responsible party - please read and sign: Mountain Eye Care complies with HIPPA. I have read the Notice of Privacy Practices. I understand that patients pay $30 per incident fees for returned checks and $30 monthly billing fees for balances overdue (60 days from date of service) or sent to collections. I know that spectacles are dress eyewear. Dr. Z recommends safety glasses for yard work and sports. Dr. Z recommends that I choose impact resistant, no-glare lenses for all eyewear. I understand that Mountain Eye Care will bill my insurance company and, according to the company's EOB, may need to collect copayments, coinsurance, and deductible amounts after my visit. I attest that the above information is accurate, that payment is due at the time of service, and that I am responsible for any balances my insurance company does not pay after 60 days.

Patient or Responsible Party Signature_____ Relationship to Patient_____
Responsible Party Legal Name_____ SS#_____
Mailing Address (if different than the above patient address)_____
Last Exam Information (When & What Office/Doctor/City) _____
Patient History: CHECK WHAT APPLIES TO YOU: Glaucoma_____ Cataracts_____ Macular Degeneration_____
Diabetic Retinopathy____ Carcinoma____ Eye Surgery____ **Hypertension____ Diabetes____ High Cholesterol____**

Family History – **PLEASE CHECK BELOW :** family members -please indicate which relative has been diagnosed with:
Glaucoma_____ Cataracts_____ Macular Degeneration_____ High BP_____ Diabetes_____
Please circle if you wear: contacts, sunglasses, distance glasses, readers, computer glasses, no-line progressives, lined bifocals
Please circle if you like to: sew, read, fish, hunt, bird, boat, play video games. Other hobbies?_____
Please circle if you experience glare, eye strain or both. When? _____
Are you here for a contact lens exam? _____ How old are your current glasses? _____ Are you interested in LASIK? _____

Please report/explain issues with any of the following (**Please circle**- use blanks to write out things not listed)**:**
Allergies/Immunologic hay-fever- lupus-HIV- rheumatoid arthritis- None **Other** _____
Eyes glaucoma- cataracts- AMD-surgery- diabetic retinopathy- vision issues- None **Other** _____
Musculoskeletal osteoarthritis- fibromyalgia- muscular dystrophy-None **Other** _____
Cardiovascular high BP- high cholesterol-heart disease-stroke-None **Other** _____
Gastrointestinal ulcers-crohn's-None **Other** _____**Neurological** MS-Alzheimer's- Parkinson's-None **Other**_____
Constitutional developmental disability-fatigue-None **Other**_____ **Genitourinary** STD-None **Other**_____
Psychiatric_____ **Ears/Nose/Mouth/Throat**_____ **Skin**_____
Blood/Lymph anemia-leukemia-None **Other**_____**Respiratory** asthma-emphysema-None **Other**_____
Endocrine insulin-dependent OR non-insulin dependent diabetes-thyroid/hormonal issues-None **Other**_____

Please circle your smoking status: current every day smoker / current some day smoker / former smoker / never a smoker
Please report your Height_____ Weight_____ and any medications/supplements you take: _____
_____
_____
Please list any medications you are allergic to:_____
Who can we thank for referring you to Mountain Eye Care?_____

If you're using Medicare for an exam, please complete the back of this form, top and bottom.
If you're using insurance of any kind, please read and sign the back of this form - top paragraph.