WELCOME TO THE OFFICE OF
DR. BRIAN COLLETTO

NAME: _____ BIRTH DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SOCIAL SECURITY NO: _____ HOME PHONE: _____ WORK: _____

LAST MEDICAL EXAM: _____ LAST EYE EXAM: _____ M: _____ F: _____

INSURANCE: _____ EMPLOYER: _____

OCCUPATION: _____ POLICY HOLDERS NAME: _____

DATE OF BIRTH: _____ SSN: _____ E-MAIL ADDRESS: _____

HAVE YOU EVER HAD LASIK? [ ] YES [ ] NO ARE YOU INTERESTED IN LASIK? [ ] YES [ ] NO

WELCOME TO OUR OFFICE -

WE ARE PLEASED THAT YOU HAVE SELECTED OUR OFFICE TO PROVIDE FOR ALL OF YOUR EYE CARE NEEDS. WE STRIVE TO PROVIDE THE HIGHEST LEVEL OF QUALITY CARE TO YOU AND YOUR FAMILY. WE ENJOY TAKING CARE OF PATIENTS OF ALL AGES, FROM YOUNG CHILDREN WITH LAZY EYES, TO ADULTS WITH SPECIAL VISUAL NEEDS SUCH AS COMPUTER GLASSES, TO SENIOR CITIZENS WITH GLAUCOMA AND CATARACTS.

FAMILY INFORMATION -

OUR OFFICE FOCUS IS ON FAMILY CARE. THEREFORE, WE LIKE TO KEEP FAMILY RECORDS TOGETHER. PLEASE LIST FAMILY MEMBERS THAT ARE PART OF YOUR HOUSEHOLD. REMEMBER THAT MANY CHILDREN HAVE A SIMILAR NEED FOR GLASSES, JUST LIKE THIER PARENTS. ADDITIONALLY , BECAUSE CHILDREN ARE GROWING SO FAST, WE RECOMMEND AN ANNUAL EYE EXAM BY A DOCTOR. TO ENSURE GOOD LEARNING IN SCHOOL.

FAMILY MEMBERS THAT HAVE BEEN EXAMINED HERE BEFORE

_____ BIRTH DATE: _____ [ ] YES

_____ BIRTH DATE: _____ [ ] YES

_____ BIRTH DATE: _____ [ ] YES

SOCIAL HISTORY -

PLEASE INDICATE HOBBIES AND INTERESTS: [ ] COMPUTERS [ ] HUNTING/FISHING

[ ] MUSIC [ ] PUBLIC SPEAKING [ ] GOLF, OTHER _____

DO YOU DRIVE? [ ] YES [ ] NO

DO YOU USE TOBACCO PRODUCTS? [ ] YES [ ] NO IF YES, TYPE/AMOUNT/HOW LONG

_____

DO YOU DRINK ALCOHOL? [ ] YES [ ] NO IF YES, TYPE/AMOUNT/HOW LONG

_____

DO YOU USE ILLEGAL DRUGS? [ ] YES [ ] NO IF YES, TYPE/AMOUNT/HOW LONG

_____

PLEASE INDICATE IF YOU HAVE BEEN EXPOSED TO OR INFECTED WITH [ ] GONORRHEA [ ] HIV
[ ] SYPHILIS [ ] HEPATITIS

FAMILY HISTORY -

PLEASE NOTE ANY FAMILY HISTORY (PARENTS, GRANDPARENTS, SIBLINGS, AND/OR CHILDREN, LIVING OR DECEASED) FOR THE FOLLOWING:

BLINDNESS	[ ] YES [ ] NO	CATARACTS	[ ] YES [ ] NO	THYROID DISEASE	[ ] YES [ ] NO
CROSSED EYES	[ ] YES [ ] NO	GLAUCOMA	[ ] YES [ ] NO	KIDNEY DISEASE	[ ] YES [ ] NO
ARTHRITIS	[ ] YES [ ] NO	CANCER	[ ] YES [ ] NO	HEART DISEASE	[ ] YES [ ] NO
DIABETES	[ ] YES [ ] NO	LUPUS	[ ] YES [ ] NO	RETINAL DISEASE	[ ] YES [ ] NO
				HIGH BLOOD PRESSURE	[ ] YES [ ] NO
				MACULAR DEGENERATION	[ ] YES [ ] NO

IF YES, WHICH RELATIVES: _____

INSURANCE AND PAYMENT POLICIES -

OUR OFFICE PROVIDES A TRAINED INSURANCE MANAGER TO ASSIST IN FILING YOUR INSURANCE. WITH YOUR PERMISSION, WE KEEP YOUR SIGNATURE ON FILE TO PROCESS YOUR CLAIMS. PAYMENT FOR SERVICES IS NEEDED AT THE TIME OF YOUR VISIT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

[ ] YES _____

(SIGNATURE AUTHORIZATION FOR INSURANCE & COLLECTION)

PLEASE CONTINUE ON BACK