James M. Beranek, O.D.
3277 Hollywood Blvd. ◆ Hollywood, FL 33021 ◆ (954) 987-6500 ◆ Fax: (954) 966-2020

Welcome To Beranek Optometry!

In order to provide you with the best possible eye care, please answer the following questions.

Name: _____ Today's Date: _____

Sex: M __ F __ Social Security #: _____ Birth date: _____/_____/_____

Home Phone: _____ Cell Phone: _____ Email: _____

Do you wear glasses □ Yes □ No Do you wear contacts? □ Yes □ No Date of Last Exam: _____/_____/_____

Any Special Eye or Vision Problems? □ Y □ No If yes, please explain: _____

_____

Reason for Today's visit:

____ General check up
____ Lost or broken glasses
____ Want new glasses
____ Blurred distance vision
____ Blurred near vision
____ Headaches
____ Want contact lenses
____ Other (Specify) _____

How were you referred to our office?

____ Friend (name) _____
____ Family (name) _____
____ Insurance plan
____ Dr Lane
____ Walk in
____ Google search
____ Other Internet search
____ Other (Specify) _____

MEDICAL AND OCULAR HISTORY – Please CHECK the appropriate box

	yes	no	Year Diagnosed	Family
1. High Blood Pressure				
2. Diabetes (Insulin, pills, diet)				
3. Thyroid				
4. High Cholesterol				
5. Heart Disease				
6. HIV / AIDS				
7. Hepatitis				
8. Arthritis				
9. Cancer				
10. Sinus				
11. Allergies				
12. Headaches				

	yes	no	Year Diagnosed	Family
13. Eye Injury				
14 Eye Surgery including Laser				
15 Cataract				
16. Cataract Implants				
17. Glaucoma				
18. Macular Degeneration				
19. Crossed Eyes				
20. Lazy Eye (Amblyopia)				
21. Floaters or Flashing Lights				
22. Blindness				
23. Other _____				

List any medications you are taking (including birth control, aspirin, over the counter medication)

_____

Acknowledgement of Receipt of *Notice of Privacy Practices*
****** FIRST TIME PATIENT ONLY ******

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office, *The Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Beranek Optometry and I authorize the release of any medical information necessary to process any claims. I also request, authorize, and assign payment of all applicable benefits to the provider of these services, and agree to pay any amount not covered.

_____ _____
Date Patient Signature

_____ _____
Date Parent/Guardian Signature if patient is Minor