WELCOME TO BROOME OPTCAL

Please help confirm your personal information

LAST NAME: _____
FIRST NAME: _____
(nick name): _____
ADDRESS: _____
CITY / STATE / ZIP: _____
HOME PHONE: _____
DAYTIME PHONE: _____
CELL PHONE: _____
TEXTING OK? YES / NO
E-MAIL ADDRESS: _____
***Please initial if your info was confirmed:** _____

SEX: M / F
DATE OF BIRTH:
SOCIAL SECURITY #
PREFERRED LANGUAGE: English / Spanish
PREFERRED (please circle) Postal
COMMUNICATION: E-mail Telephone
RACE: (please circle) American Indian or Alaska Native / Asian / Black or African American / Hispanic / Native Hawaiian or Other Pacific Island / White
ETHNICITY: (please circle) Hispanic or Latino / Native Hawaiian or Other Pacific Island / Not Hispanic Latino
DRIVER'S LICENSE #
OCCUPATION or GRADE:

EMPLOYER/SCHOOL:

Are you here for: **Contact Lenses** _____ **Eyeglasses** _____ **Examination** _____ **Red Eye** _____

MEDICAL HISTORY (please circle)

Allergy
Cardiovascular (Heart)
Constitutional
Endocrine (Diabetes)
Gastrointestinal (Stomach)
Genitourinary (Bladder)
Ears, Nose, Mouth, Throat
Hematologic/Lymphatic
Immunologic/Autoimmune
Integumentary (Skin)
Musculoskeletal (Bones)
Neurological (Brain/Nerves)
Psychiatric
Respiratory (Lung Disease)

PUPIL DIALATION (please circle)

I (DO) or (DO NOT) wish this procedure.

I realize that this choice may or may not limit the ability of my doctor diagnosing some diseases or disorders.

***We strongly encourage our patients to supply a copy of medications to be verified in the exam room.**

If you are a new patient, whom may we thank for referring you today? _____

I hereby authorize Broome Optical to file my insurance and authorize the use of my signature on all my insurance submissions. I understand I am responsible for all charges and will pay for any amount applied to my deductible, co-insurance, and non-covered services. I agree to be personally and fully responsible for payment if I have not obtained prior authorization. ***PLEASE BRING ALL INSURANCE CARDS TO EACH APPOINTMENT.***

Primary Medical Ins. Policy holder: _____ SSN: _____ DOB: _____
Vision Ins. Policy holder: _____ SSN: _____ DOB: _____

HIPAA NOTICE: By signing below, I acknowledge that I have read or have received a copy of Broome Optical / *Notice of Privacy Practices.*

RESPONSIBLE PARTY/GUARANTOR: _____ **Date:** _____

Signature: _____ **Date:** _____