Dr. Scott i. Morrison
OPTOMETRY, P.C.

Scott I. Morrison, O.D, F.A.A.O. · The Professional Center · 243 Main Street · Suite 120 · New Paltz, NY 12561 · (845) 255-4696
2294 Route 208, Suite 7 · Montgomery, NY 12549 · (845) 778-3591

PATIENT INFORMATION			
Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**	**Age:**
Preferred Name:	**Soc. Sec. #:**		
Street Address:	**City:**	**ST:**	**Zip:**
Home Phone:	**Cell Phone:**	**Work Phone:**	
Preferred Language: ☐ English ☐ Spanish	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Native Hawaiian/Other Pacific Island	**Race:** ☐ White ☐ Black or African American ☐ Hispanic ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian/Other Pacific Island	
Communication Preference: ☐ Email ☐ Postal ☐ Telephone	**Referred by:** ☐ Patient ☐ Doctor ☐ Insurance	**Ref. Name:**	
Email address:	**Email OK:** ☐ Yes ☐ No	**Text Message OK:** ☐ Yes ☐ No	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Emergency Contact:	**Phone:**		
Occupation:	**Employer:**		
Primary Care Physician:	**Phone:**		
Special Vision Requirements:			
Sports/Activities:			

INSURANCE INFORMATION					
Is this Patient under 18 years of Age? ☐ Yes ☐ No	If yes, please complete the Person responsible for bill section				
Person responsible for bill	**Date of Birth** / /	**Address (if different):**		**Home phone no.** ( )	
Is this person a patient here? ❑ Yes ❑ No	If yes, indicate patients name:				
Primary Insurance Carrier Name:					
Subscriber's name:	**Subscriber's S.S. #:**	**Birth date:** / /	***Group no.:***	***Policy no.:***	***Co-payment:*** $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary Insurance Carrier Name:					
Subscriber's name:	**Subscriber's S.S. #:**	**Birth date:** / /	***Group no.:***	***Policy no.:***	***Co-payment:*** $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

CONCERNING INSURANCE

Patients who are a member of a plan with which we participate are responsible at the time of service for all co-pays, deductibles and non-covered services and materials. Patients who are members of a plan with which this office does not participate are fully responsible for all procedures and materials at the time of service. Medicare patients are responsible for their refraction, all materials and charges applied to their deductible and 20% of the office fees once the deductible has been satisfied.

I have read the above and fully understand my financial responsibilities for all services and materials received in this office.

Signature:	**Printed Name:**	**Date:**

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Patient Name:	Date of Birth:	Today's Date:

Medical History	Details/Additional Information
ALLERGY	
Food ☐ Animals ☐ Seasonal ☐	
CARDIOVASCULAR	
Hypertension ☐ Cholesterol ☐ Stroke ☐	
CONSTITUTIONAL	
Appetite ☐ Fever ☐ Dizziness ☐ Weight loss/gain ☐	
ENDOCRINE	
Thyroid ☐ Diabetes ☐ Pituitary ☐ Gout ☐	
GASTROINTESTINAL	
Acid reflux ☐ Colitis ☐ Ulcer ☐	
GENITOURINARY	
Prostrate ☐ Kidney ☐ Bladder ☐	
EARS, NOSE, THROAT	
Sinus ☐ Ear infections ☐ Tonsils ☐	
HEMATOLOGIC/LYMPHATIC	
Anemia ☐ Polycythemia ☐ Hemophilia ☐	
IMMUNOLOGIC	
Autoimmune ☐ Rheumatoid arthritis ☐ Sjogrens ☐	
INTEGUMENTARY (SKIN)	
Psoriasis ☐ Eczema ☐ Acne ☐ Rosacea ☐	
MUSCULOSKELETAL	
Arthritis ☐ Osteoporosis ☐	
NEUROLOGICAL	
Migraine ☐ Multiple sclerosis ☐ Parkinson's ☐	
PSYCHIATRIC	
Anxiety ☐ Depression ☐	
RESPIRATORY	
Asthma ☐ COPD ☐ Emphysema ☐	

MEDICATION ALLERGIES/REACTIONS

PAST SURGERIES

VISUAL HISTORY

Do you experience or been Diagnosed with any of the following conditions:

☐ Blurry Vision ☐ Headaches ☐ Computer strain ☐ Glaucoma ☐ Double Vision ☐ Burning ☐ Eye fatigue
☐ Macular Degeneration ☐Loss of Vision ☐ Redness ☐ Poor reading comprehension ☐ Cataracts ☐ Tearing
☐ Flashes/Floaters ☐ Night vision ☐ Eye turn ☐ Eye pain ☐ Eyestrain ☐ Lazy eye

OCULAR MEDICATIONS:			
When was your last eye exam?	/ /		
Were your eyes dilated?	☐ No ☐ Yes	**ANY FAMILY HISTORY OF**	**RELATIONSHIP TO YOU**
Do you wear contacts?	☐ No ☐ Yes	☐ Glaucoma	
Are you interested in Laser Vision Correction?	☐ No ☐ Yes	☐ Diabetes	
		☐ Macular Degeneration	
Are you interested in contact lenses?	☐ No ☐ Yes	☐ High Blood Pressure	
		☐ Blindness	