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

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

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HIPAA-ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

Dr. Scott I. Morrison OPTOMETRY, P.C. is required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. A copy of this notice will be provided upon request.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

Contact Person: Our contact person for all questions, requests or further information related to the privacy of your health information is Eric Waldheim 845-255-4696 x.302.

_____

Signature of patient or patient's representative/parent

Date: _____

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient

Form Updated
3/25/2021