OKEMOS
OPTOMETRY, P.C.

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Protecting Patients
New Safety Protocols

We're thinking of you during this difficult time. The health and safety is always our top priority, and now is no different.

1. Please have all paperwork completed before your appointment. If possible please take a picture of your ID and Insurance Card and email to okemosoptometrypc@gmail.com

2. The door will be locked. Please call the office **517-349-8888** when you are in the parking lot and we will admit you.

3. Each Exam rooms and all equipment is sanitized after every patient.

4. We are requiring all patients to wear a mask during your visit. Staff are wearing surgical masks and gloves for all contact with patients.

5. All patients will be asked screening questions upon arrival and you will have your temperature measured.

6. Visits are limited to the patient only unless the patient requires assistance or a minor patient accompanied by one parent.

We hope you and your families are staying safe! If you have any questions or concerns, please do not hesitate to contact us at 517-349-8888.

Welcome to Okemos Optometry

Patient Information

Name: Last _____ First _____ MI _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: Cell (____) _____ OK to Text ☐ Yes / ☐ No Home (____) _____
Email: _____
Social Security Number: _____ Date of Birth: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Preferred Language: _____ Race:_____ Ethnicity:_____
Employer: _____ Occupation: _____
Emergency Contact: _____
Phone: (____) _____ Relationship: _____

Insurance Information: *Please present ALL insurance cards*
Primary Vision Insurance Provider: _____ ID: _____
Member Name: _____ Date of Birth: _____
Secondary Vision Insurance Provider: _____ ID: _____
Member Name: _____ Date of Birth: _____
Primary Medical Insurance Provider: _____ ID: _____
Member Name: _____ Date of Birth: _____
Secondary Medical Insurance Provider: _____ ID: _____
Member Name: _____ Date of Birth: _____

Health History
Eye History:
Last Eye Exam: _____ Location of last eye exam: _____
Glasses: ☐ Yes / ☐ No Contacts: ☐ Yes / ☐ No Brand/Type: _____
Reason for today's visit:_____
_____
Have you or a family member experienced or been treated for any of the following visual issues:
☐ Cataracts ☐ Cross Eye ☐ Glaucoma ☐ Lazy Eye ☐ Macular Degeneration ☐ Retinal Detachment
☐ Lasik/PRK Other _____
Please Explain: _____

Medical History:
Have you or a family member experienced or been treated for any of the following health issues:
☐ AIDS/HIV ☐ Allergies ☐ Arthritis ☐ Asthma ☐ Blood/Lymph Disorder ☐ Cancer ☐ Diabetes
☐ Heart Disease ☐ High/Low Blood Pressure ☐ High Cholesterol ☐ Lupus ☐ Neurological Conditions
☐ Psychiatric Disorder ☐ Seizures ☐ Skin Conditions ☐ Thyroid Dysfunction Other _____
Please Explain: _____
_____
Current Medications (prescription and over-the-counter): _____
_____
_____
Medication Allergies: _____
_____

Height:_____ Weight: _____
Are you pregnant/nursing? ☐ Yes / ☐ No
Do you smoke? ☐ Yes / ☐ No Use other substances? ☐ Yes / ☐ No Drink alcohol? ☐ Yes / ☐ No
How did you hear about us? _____