Ducklo Eye Group

Mr Miss Mrs Ms Dr | Last Name | First Name | Middle | Preferred Name | Sr Jr III IV

Address | City | State | Zip Code | Date of Birth

Social Security Number | Sex ( ) M ( ) F | Home Phone ( ) Preferred | Work Phone ( ) Preferred | Cell Phone ( ) Preferred ( ) Text

Email Address ( ) include as a contact method

Employment / School Status
☐ Employed ☐ Unemployed ☐ Retired Student: ☐ Full-time ☐ Part-time

Employer or School

Date of Last Eye Exam | Previous Eye Doctor | Phone

Emergency Contact | Relationship | Phone

Date of Last Physical Exam | Primary Medical Doctor | Phone

Preferred Language:

Name of Pharmacy | Location of Pharmacy | Phone

Race
☐ American Indian or
☐ Asian
☐ Black or African American
☐ Middle-Eastern
☐ Native Hawaiian/Pacific Islander
☐ White or Caucasian
☐ Other Race
☐ Declined

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Declined to state

Marital Status
☐ Single ☐ Divorced
☐ Married ☐ Widowed
☐ Partner ☐ Other

Vision Concerns

☐	Blurred Vision	☐	Headache
☐	Eyestrain	☐	Poor night vision
☐	Eye Pain	☐	Double Vision
☐	Sensitivity to lights	☐	Total Vision Loss

Eye Conditions

☐	Cataracts	Right Left Both
☐	Cataract Surgery	Date of Surgery _____
☐	Macular Degeneration	Right Left Both
☐	Glaucoma	Right Left Both
☐	Diabetes	A1-C: Fasting Blood Sugar:
☐	Diabetic Retinopathy	
☐	Dry Eye	Right Left Both
☐	Infection/Inflammation	Right Left Both
☐	Allergy/ Itching	Right Left Both
☐	Floaters	Right Left Both
☐	Flashes of Light	Right Left Both
☐	Iritis or Uveitis	Right Left Both
☐	Retina defects/degeneration	Right Left Both
☐	Strabismus/Lazy Eye	Right Left Both
☐	Lasik or PRK	Date of Surgery _____
☐	Other:_____	

☐ I have a CDL (Commercial Drivers License)

☐ I am Currently Pregnant _____Weeks

Contact Lens Services

☐ **I currently wear Contacts**

Current Brand_____

R:_____L:_____

I replace them every:_____

☐ Day(s) ☐ Week(s) ☐ Month(s)

I Sleep in my Contacts: ☐ Never ☐ Occasionally ☐ Every Night

I Clean my Contacts with:
☐ Clear Care ☐ OptiFree
☐ Renew ☐ Biotrue ☐ Revitalens
☐ Generic ☐ Other _____
☐ I Do Not Clean my Contacts

☐ I do not currently wear contacts, but would like to.

Authorization for the use and disclosure of individually identifiable health information

In order to provide the best and most efficient patient retention program, we ask for your permission to share some basic demographic information with LensCrafters and Solution Reach. This reduces duplicate mailing, notifications and keeps you informed of future visits and offers/discounts. These entities do not receive any compensation as a result of this information. The shared information is limited to name, address, telephone number, email address, and appointment date and times. A copy of the information used or disclosed may be obtained at any time and may be revoked at your written request. This authorization expires four years from this date.

☐ I hereby authorize the use and disclosure of my individual identifiable health information from James L Ducklo, O.D. And Associates to LensCrafters and Solution Reach.

☐ I do not want my demographic information shared with LensCrafters and Solution Reach.

For purposes of contacting our Patients, we do require one method of communication. This is for notification by our staff to inform you of your upcoming appointment, scheduling issues, referral appointments, insurance information and notification of eyewear arrivals.

Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell ☐ Text ☐ Email

Notice of Private Practice - A copy of our office policies is available at your request

Accepted Methods of Payment

Cash MasterCard Visa American Express Discover Synchrony LensCrafters Card Care Credit

We Do Not accept Personal Checks

Thank You for allowing us to serve your vision care needs.

I have read the above policies. I understand and agree to these policies.

_____ _____

Signature of Patient or Legal Guardian (if minor) **Today's Date**