
***Wafa Abdulrazzaq, OD***

***Board Certified Optometric Physician***

Eye Q Optical ~ 8711 Stirling Road ~ Cooper City, Florida 33328 ~ Phone 954.434.1414 Fax 954.434.1717


## Patient Demographic Form

Patient's Name:_____ _____ _____
First MI Last

Nickname:_____ Date of Birth:_____ SSN#:_____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Purpose of Visit: Routine Eye Exam:_____ Contact Lens Fitting:_____
Medical Office Visit:_____ Other:_____

## Primary Insurance Information

Insurance Co: _____ Group # _____

Primary Policy Holder's Name: _____

Employer:_____ Work Phone#:_____

Address: _____ Birth Date _____

Subscriber's SSN#: _____

Secondary Insurance Information:_____ Group # _____

NOTE: Every effort will be made to collect payment from your insurance company. However authorizations do not quarantee payment and in the event that a claim can not be processed, patient's assume all financial responsibilities. The HIPAA Privacy Act has been read.

**Patient Signature:**_____ **Date:**_____

**Parent/Guardian Signature Required for Minor Children:**_____

## Patient Health History

Last Eye Exam: _____ Last Physical Exam: _____

Do you wear Contact Lenses? _____

Do you wear Glasses? _____ Full Time:_____ Sometimes:_____

Are your Glasses: Distance Only:____ Reading Only: ____ Progressives/bifocals____

Have you experienced any of the following (please check):

| | | |
|---|---|---|
| Glaucoma:_____ | Amblyopia (lazy eye):___ | Diabetes:____ |
| Cataracts:_____ | Strabismus (cross eye):___ | Hypertension:_____ |
| Retinal Disease:_____ | Blurred Vision at Distance:____ | Loss of Vision:_____ |
| Itching: _____ | Blurred Vision at Near:____ | Floaters or Spots:_____ |
| Headaches:_____ | Watery Eyes:_____ | Burning:_____ |

Other:_____

List all known allergies:_____

As of January 1, 2017 there will be a $5 charge per additional copy of your RX or invioce after the date of your exam.

**Patient Signature:**_____ **Date:**_____