Welcome to the Office of Dr. Erik Ostenso

Name_____ If child, parents' name _____

Address _____

Employer_____ Spouse's employer _____

Home phone_____ Work phone _____

Cell phone_____ E-mail _____

Emergency contact - name_____ Phone # _____

Please allow us to copy cards for any insurance companies that we should bill for your eyecare.

How did you hear about us? _____

Thank you for giving us the opportunity to help you care for your vision.

Dr. Erik Ostenso and his staff are dedicated to providing each and every patient with the highest quality eyecare, eyewear and contact lenses. We have a 100% satisfaction guarantee policy. Our frames are completely warranted for one year. Our lenses have a one year warranty for scratching and chipping which covers a one time redo in the first year. Sorry, these warranties cannot apply to safety and medical assistance glasses.

If you need a duplicate pair of glasses or some prescription sunglasses, we hope you will take advantage of our Two Pair discount. After a full price purchase, second pairs purchased by the same patient on the same day are 25% OFF. Also, please ask about our family and senior discounts.

Please sign: I authorize the release of any medical information necessary for my eyecare and for billing services to my insurance company. I understand that I am financially responsible for all charges that are not covered by insurance. Payment is due at the time services are rendered.

Signed_____ Date _____

I acknowledge that I have received a copy of the Notice of Privacy Practices from the office of Erik A. Ostenso, O.D.

Signed_____ Date _____

Health History

Date_____

Occupation/School Grade_____

Hobbies _____

Have you ever been diagnosed with: Cataracts **Y / N** Glaucoma **Y / N** Macular Degeneration **Y / N**
Retinal Detachment **Y / N** Other eye problems _____

Have you ever had any surgeries? **Y / N** If yes, please explain _____

Have family members been diagnosed with: Cataracts **Y / N** Glaucoma **Y / N** Macular Degeneration **Y / N**
Retinal Detachment **Y / N** Other eye problems _____

Has anyone in your family been treated for: Hypertension **Y / N** Diabetes **Y / N**

Please mark any conditions that apply to you or mark "none" if none apply.

Constitutional None___
- ❑ developmental disability
- ❑ weight loss
- ❑ fever
- ❑ fatigue
- ❑ trauma
- ❑ other/medications

Ears, Nose, Mouth & Throat None___
- ❑ upper respiratory tract infection
- ❑ other/medications

Cardiovascular None___
- ❑ heart disease
- ❑ hypertension
- ❑ stroke
- ❑ vascular disease
- ❑ other/medications

Respiratory None___
- ❑ cigarette smoker
- ❑ asthma
- ❑ bronchitis
- ❑ emphysema
- ❑ other/medications

Gastrointestinal None___
- ❑ Crohn's
- ❑ colitis
- ❑ ulcer
- ❑ digestive
- ❑ other/medications

Genitourinary None___
- ❑ Urinary tract infections
- ❑ kidney ailments
- ❑ STD-viral herpetic, chlamydia
- ❑ other/medications

Musculoskeletal None___
- ❑ fibromyalgia
- ❑ muscular dystrophy
- ❑ osteoarthritis
- ❑ ankylosing spondylitis
- ❑ other/medications

Integumentary None___
- ❑ eczema
- ❑ rosacea
- ❑ psoriasis
- ❑ other/medications

Neurological None___
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ other/medications

Psychiatric None___
- ❑ depression
- ❑ panic disorder
- ❑ schizophrenia
- ❑ other/medications

Endocrine None___
- ❑ non-insulin dependent diabetes
- ❑ insulin-dependent diabetes
- ❑ thyroid dysfunction
- ❑ hormonal dysfunction
- ❑ other/medications

Hematological/Lymphatic None___
- ❑ anemia
- ❑ large volume blood loss
- ❑ leukemia
- ❑ other/medications

Allergic/Immunologic None___
- ❑ drug allergy
- ❑ environmental allergy
- ❑ rheumatoid arthritis
- ❑ lupus
- ❑ other/medications

Please list medications:

_____
_____
_____

Are you allergic to any medications? **Y / N** If yes, please list_____

Do you have any of the following? If yes, please check the box.

❑ Dry eyes ❑ Blurred Vision ❑ Eye injury, when _____

❑ Itchy eyes ❑ Headaches ❑ Allergies _____

Do you wear: ❑ Glasses ❑ Sunglasses ❑ Contacts Do you sleep in your contacts? **Y / N**

Do you have any questions about eye issues? _____

Are you bothered by bright sunlight? **Y / N** Are you bothered by glare or night driving **Y / N**

What do you like most about your current glasses? _____

What do you dislike about your current glasses? _____

Doctor Initials:_____