Oklahoma Eye Institute

Data Sheet

Account #

First Name:_____ Middle Initial:_____ Last Name: _____SS# _____

Address:_____ City: _____ State:_____ Zip: _____

Date of Birth _____ Age :_____ Marital Status: _____ Sex: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Other/Emergency Phone _____ **E-mail:** _____ **Driver License #** _____

Optometrist: _____ Referring Physician:_____ Primary Care Physician: _____

How did you hear of OEI? (circle) Family or Friend Insurance Plan Optometrist TV Ad Other _____

Employer: _____

Emp Address: _____ City/State/Zip: _____

Insurance Information

Primary Insurance: _____ I.D. #: _____ Group#: _____

Secondary Insurance: _____ I.D. #: _____ Group#: _____

Primary Insured/ Responsible Party Information (If different from patient information)

Name: _____ Relationship to patient _____ SS # _____

Address_____ **City**_____ **State** _____ **Zip Code** _____

Date of Birth: _____Age : _____ Marital Status: M S D W Sex: M F

Home **Phone** ___ Work Phone (____)_____ Cell Phone(_____)_____

Employer:_____

Visit Information

Reason for your visit? _____

If this visit is due to an accident, please provide accident date _____

Privacy Information

Friend/relative whom we may contact in an emergency and/or regarding your visit if necessary? (HIPAA compliance):

1) _____ Relationship: _____ Phone #: _____

2) _____ Relationship: _____ Phone #: _____

I certify that I have been informed about the OEI Patient Information Privacy Notice: Also, visit our website at https://www.oklahomaeyeinstitute.com/about-us/oklahoma-eye-institute-privacy-notice/

_____ _____ _____

Patient Signature Date OEI Employee

Authorization of Care

I authorize Oklahoma Eye Institute to examine me and perform such tests and procedures as are reasonable and necessary in the diagnosis and treatment of my care. If I am not the patient, but instead signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient's behalf.

Patient's Signature_____Date_____

Representative's Signature_____Date_____

Relationship of Representative to Patient _____

Oklahoma Eye Institute

Patient Communication Consent Form

At Oklahoma Eye Institute, we strive to provide you with excellent care and timely communication. By signing this form, you consent to receive messages from Oklahoma Eye Institute regarding your scheduled and unscheduled appointments through the following methods:

- **Email**
- **SMS (Text Messages)**
- **Phone Calls**

Consent Details:

- By providing your contact information, you agree to receive communications from Oklahoma Eye Institute related to appointment reminders, scheduling updates, and other relevant notifications.
- **SMS Messages**: You may receive text messages that include appointment reminders and updates. Message frequency may vary. Standard message and data rates may apply.
- **Opt-Out Option**: You can reply **STOP** at any time to opt out of receiving further text messages from Oklahoma Eye Institute. For additional support, you may reply **HELP** or contact our office directly at our Lawton location at 580-536-0000 or our Elk City location at 580-225-1555.
- **Privacy Policy**: For more information about how we protect your information, please review our privacy policy available on our website at: https://www.oklahomaeyeinstitute.com/about-us/oklahoma-eye-institute-privacy-notice/

Patient Acknowledgment:

I understand that message and data rates may apply, and that I may opt out of receiving text messages at any time by replying **STOP**. I also acknowledge that I have been informed about Oklahoma Eye Institute's privacy policy.

By signing below, I am opting in to receive communications from Oklahoma Eye Institute through the contact information I have provided below.

Patient Name: _____
Date of Birth: _____
Phone Number to receive SMS messages / Phone Calls: _____
Email: _____

Signature: _____
Date: _____

Oklahoma Eye Institute

PATIENT NAME: _____
DATE: _____
DOB: _____

MEDICAL HISTORY (*CIRCLE ALL THAT APPLY)*

ANXIETY ARTHRITIS RHEUMATOID ARTHRITIS CANCER:TYPE_____ DIABETES:TYPE_____ AIC:_____ HISTORY OF HEAD TRAUMA HISTORY OF EYE TRAUMA HISTORY OF HEART ATTACK HIV HEART DISEASE HEPATITS:TYPE_____ HIGH BLOOD PRESSURE HIGH CHOLESTEROL LUNG PROBLEMS:TYPE _____ HISTORY OF HEART ATTACK	LUPUS MIGRAINES PSYCHIATRIC PROBLEMS PACEMAKER IMPLANT SLEEP APNEA SHINGLES STROKE THYROID PROBLEMS TUBERCULOSIS TAKEN FLOMAX? Y or N OTHER HEALTH HISTORY:_____ _____ _____ _____ _____ _____	**DO YOU HAVE OR HAD?** ***CATARACTS** ***GLAUCOMA** ***MACULAR DEGENERATION** ***RETINAL DETACHMENT** _____ **HAVE YOU TAKEN FLOMAX Y OR N?**	**ALL SURGERIES** *(INCLUDING EYE)* _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _

CURRENT MEDICATIONS:

_____

_____

_____

FAMILY HISTORY:
CATARACTS YES NO WHOM:_____
GLAUCOMA YES NO WHOM:_____
DIABETES YES NO WHOM:_____
MACULAR DEGENERATION YES NO
WHOM:_____
RETINAL DETACHMENT YES NO
WHOM:_____

DRUG ALLERGIES:

_____
_____
_____
_____
_____

PHARMACY NAME: _____ LOCATION: _____

SOCIAL HISTORY:
ALCOHOL USE: YES NO
SMOKE: YES NO YEARS:_____
TOBACCO: YES NO YEARS:_____

HAVE YOU HAD A:
FLU SHOT THIS YEAR: YES NO

PNEUMONIA SHOT THIS YEAR: YES NO

DO YOU WEAR CONTACTS? YES NO

DAILY? YES NO

HOW LONG?_____

_____