Welcome To Our Office

Date:_____/_____/_____ Gender: M F

Patient's Name:____

Last Middle First

Date of Birth:______/________/_________ Home Phone: (____)______________________

Cell Phone: (____)______________________ Email Address:______________________

Address:____

City:______________________State:______________Zip:______________

School:______________________________ Grade:______________________

Employer:______________________________ Occupation:______________________

Name of Insurance Policy Holder: ______________________________

Policy Holder's SS#______________________ Policy Holder's DOB______/______/______

Secondary Policy Holder/ Spouse: ______________________________

2nd Policy Holder's SS#: ______________________ 2nd Policy Holder's DOB: ______/______/______

Vision Insurance:

☐ Medicare ☐ VSP ☐ MES ☐ EyeMed ☐ Cal-Alliance ☐ Private Pay

Medical Insurance:______________________________

Whom may we thank for referring you to this office? ______________________________

Signature of party responsible for payment : ______________________________

Medical History Questionnaire

Name: ______________________________ Date: _____/_____/_____

Birth Date: _____/_____/_____ Last Medical Exam: _____/_____/_____ Last Eye Exam: _____/_____/_____

Name of Medical Doctor: ______________________________ Dr.'s Phone: ______________

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: ______________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: ______________

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury? ______________

Are you pregnant and/or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? ______________

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? ______________

Type of contact lenses? ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

Family History

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions.

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	______________
Cataract	❒	❒	❒	______________
Crossed Eyes	❒	❒	❒	______________
Glaucoma	❒	❒	❒	______________
Macular Degeneration	❒	❒	❒	______________
Retinal Detatchment/Disease	❒	❒	❒	______________
Arthritis	❒	❒	❒	______________
Cancer	❒	❒	❒	______________
Diabetes	❒	❒	❒	______________
Heart Disease	❒	❒	❒	______________
High Blood Pressure	❒	❒	❒	______________
Kidney Disease	❒	❒	❒	______________
Lupus	❒	❒	❒	______________
Thyroid Disease	❒	❒	❒	______________
Other ______________	❒	❒	❒	______________

Social History

Do you Drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe: ______________

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: ______________

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: ______________

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: ______________

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Syphilis ❒ HIV ❒ Hepatitis

✸*Please turn this form over and complete side two*✸

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

SYSTEM	NO	YES	?	EXPLAIN / MEDICATIONS
INTEGUMENTARY (Skin)	☐	☐	☐	
NEUROLOGIC				
Headaches	☐	☐	☐	
Migraines	☐	☐	☐	
Seizures	☐	☐	☐	
EYES				
Loss of Vision	☐	☐	☐	
Blurred Vision	☐	☐	☐	
Distorted Vision/Halos	☐	☐	☐	
Loss of Side Vision	☐	☐	☐	
Double Vision	☐	☐	☐	
Dryness	☐	☐	☐	
Mucous Discharge	☐	☐	☐	
Redness	☐	☐	☐	
Sandy or Gritty Feeling	☐	☐	☐	
Itching	☐	☐	☐	
Burning	☐	☐	☐	
Foreign Body Sensation	☐	☐	☐	
Excess Tearing/Watering	☐	☐	☐	
Glare/Light Sensitivity	☐	☐	☐	
Eye Pain or Soreness	☐	☐	☐	
Chronic Infection of Eye or Lid	☐	☐	☐	
Sties or Chalazion	☐	☐	☐	
Flashes/Floaters in Vision	☐	☐	☐	
Tired Eyes	☐	☐	☐	
EARS, NOSE, MOUTH, THROAT				
Allergies	☐	☐	☐	
Hay Fever	☐	☐	☐	
Sinus Congestion	☐	☐	☐	
Runny Nose	☐	☐	☐	
Post Nasal Drip	☐	☐	☐	
Chronic Cough	☐	☐	☐	
Dry Throat/Mouth	☐	☐	☐	
RESPIRATORY				
Asthma	☐	☐	☐	
Chronic-Bronchitis	☐	☐	☐	
Emphysema	☐	☐	☐	
VASCULAR				
Diabetes	☐	☐	☐	
Heart Pain	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Vascular Disease	☐	☐	☐	
GASTROINTESTINAL				
Diarrhea	☐	☐	☐	
Constipation	☐	☐	☐	
GENITOURINARY (genitals/kidney/bladder)	☐	☐	☐	
BONES/JOINTS/MUSCLES				
Rheumatoid Arthritis	☐	☐	☐	
Muscle Pain	☐	☐	☐	
Joint Pain	☐	☐	☐	
LYMPHATIC/HEMATOLOGIC				
Anemia	☐	☐	☐	
Bleeding Problems	☐	☐	☐	
ENDOCRINE (thyroid/other glands)	☐	☐	☐	
PSYCHIATRIC	☐	☐	☐	

Doctor's Signature ______________________ Review Date ______________________

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CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT CARE OPERATIONS.

Patient Name: ______________________________
Patient Phone number: ______________________________
Patient Address: ______________________________

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practice that describes these uses and disclosure in detail. You are free to refer to this Notice at this time before you sign this consent document. As described in our Notice of Privacy Practice, the use and disclosure of your health information for the treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Date: ______________ Patient Signature ______________________________

If you are signing as a personal represenitive of the patient, describe your relation ship to the patient and the source of your authority to sign this form:

Relationship to patient: ______________________________

Signature of Authority: ______________________________