

WELCOME TO OUR OFFICE

It is our objective to provide you with the finest vision care possible. To do this it is necessary for us to know as much as possible about your visual needs and present health condition. If at any time you have questions concerning your vision, the visual exam and care, or about our fees we encourage you to ask.

PLEASE FILL OUT ALL INFORMATION AS IT APPLIES TO THE PERSON BEING EXAMINED
(ALL INFORMATION IS CONFIDENTIAL)

Today's Date: _____ Date of Birth: _____ Age: _____

Patient's Name: _____ Spouse: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Work Phone: _____

Cell Phone: _____ E-mail address: _____

Employer: _____ Occupation: _____

If under age 18 - Parents' name: _____ School: _____ Grade: _____

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Whom may we thank for referring you?

Friend/Family (Name) _____ Doctor: _____ Phone Book: _____

Insurance Co. _____ Internet: _____ Other: _____

Date of last comprehensive eye exam: _____ Doctor: _____ City: _____

Have you ever worn contacts: () Yes () No....if yes, what kind? () Soft () Rigid

Please check any of the following reasons for this exam..

Routine checkup _____ New frame or lenses _____ Contact lenses desired _____ Sunglass interest _____

Refractive (Laser) surgery interest _____ Glasses for computer _____ Other _____

OFFICE POLICY: Services - payment is expected at the time services are rendered.
Materials - 50% minimum required prior to ordering and balance on dispensing.

A 1.5% service charge will be added to any balances over 30 days old, with a minimum charge of \$1.50. There is a \$20.00 fee for returned checks. Accounts over 90 days old will be sent to our collections and additional fees may occur.

Check if you have any of the following insurance:

1. () Vision Service Plan (VSP) 2. () Medicare 3. () MediCal 4. () Medical Eye Services
5. () Superior Vision Plan 6. () Other _____

TERMS & CONDITIONS: I understand that responsibility for all charges whether or not paid by insurance, including any deductible or co-payment amount and non-covered services for myself or my dependents is mine, due and payable at the time services are rendered. I understand that the office will assist me in submitting the appropriate insurance form(s), and that differences in the amount paid by the insurance company and actual charges may be my responsibility. My signature & SS# below indicates my permission to the doctors to bill my insurance and to act as my agent in any insurance matters that pertain to my vision.

Signed: _____ Last 4 numbers of SS# _____

MEDICAL HEALTH QUESTIONNAIRE

IMPORTANT: THIS QUESTIONNAIRE IS TO BE REVIEWED AT EACH APPOINTMENT. PLEASE ANSWER ALL OF THE QUESTIONS. ALL INFORMATION PROVIDED BY YOU WILL BE HELD IN THE STRICTEST CONFIDENCE IN ACCORDANCE WITH OUR PRIVACY PRACTICES. WE WILL NOT DISCLOSE YOUR HEALTH INFORMATION UNLESS YOU SIGN A WRITTEN AUTHORIZATION FORM.

NAME: _____ DATE: _____

Name of Medical Dr _____ Dr's Phone No: _____

How is your general Health? _____ Last Medical Exam: _____ / _____ / _____

Do you have problems with any of the following systems? (Circle yes or no)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Eyes	Yes/No	Muscles/Bones	Yes/No
Skin	Yes/No	Mental	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Respiratory	Yes/No	Allergic/Immunologic	Yes/No

Please explain any yes answers: _____

Diabetes Yes/No Type: _____ Date of Diagnosis: _____

Any other health problems? _____

Any allergies to medications? Yes/No If yes, please list: _____

Current medication(s): _____

Operations? Yes/No When: _____ For: _____

Are you pregnant? Yes/No Nursing? Yes/No

Family History

High blood pressure Yes/No Relation _____ Diabetes Yes/No Relation _____

Macular degeneration Yes/No Relation _____ Glaucoma Yes/No Relation _____

Retinal detachment Yes/No Relation _____ Cataracts Yes/No Relation _____

Personal Eye Information

Do you have any eye conditions or problems? If so, what kind? _____

Have you had any eye operations? If so, what type: _____ Date _____

Eye injuries? Yes/No Type: _____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Do you wear glasses? Yes/No Contacts? Yes/No Type: _____

Any additional information? _____

DOCTOR USE ONLY: Reviewed by: _____ Date: _____

Reviewed by: _____ () No changes Date: _____

Reviewed by: _____ () No changes Date: _____

Reviewed by: _____ () No changes Date: _____

Reviewed by: _____ () No changes Date: _____