**WELCOME TO OUR OFFICE**

**DateToday**  **Appointment:**

**Name:** **DOB:** **Age: \_\_\_\_\_\_\_**

**Address**:

**City/Zip:**

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_

**Email**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Texting Ok

**Driver's License:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Exp. Date:\_*\_\_\_\_\_\_ **Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status:** *Single / Married / Divorced / Widowed*

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employment Status:** *Full Time / Part Time / Student / Unemployed*

Have you been here before? ***Yes / No*** Last Exam Date: \_\_\_\_\_\_\_\_\_\_

Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Reason for this exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Are you currently wearing glasses*? ­\_\_\_\_ *Contact Lenses*?\_\_\_\_

*Are you interested in contact lenses*?\_\_\_\_*Are you interested in corrective laser eye surgery*?\_\_\_\_

How many hours a day do you spend at the computer? \_\_\_\_\_\_\_\_

**Please indicate any of the following that apply to you:**

\_\_\_ High Blood Pressure \_\_\_ Eyes Water \_\_\_Blur at Distance

\_\_\_ Heart Trouble \_\_\_ Eyes Itch \_\_\_Blur Near

\_\_\_ Diabetes \_\_\_ Eye Strain \_\_\_Blur After Reading

\_\_\_ Thyroid \_\_\_ Eye Fatigue \_\_\_Difficulty Re-Focusing

\_\_\_ Lupus \_\_\_ Eye Injury \_\_\_Double Vision

\_\_\_ Rheumatoid Arthritis \_\_\_ Eye Surgery \_\_\_Headache

\_\_\_ Asthma \_\_\_ Eye Disease \_\_\_Dry Eyes

\_\_\_ Emphysema \_\_\_ Color Blindness \_\_\_Skip Words

\_\_\_ Glaucoma \_\_\_ Seeing Spots \_\_\_Reading Problems

\_\_\_ Seasonal Allergies \_\_\_ Light Flashes \_\_\_Difficulty Driving at Night

\_\_\_ Pregnancy mo \_\_\_\_ \_\_\_ Sensitive to Light \_\_\_Bothered by Glare

Medications used at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? ***Yes / No*** If Yes to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History of Eye Disease or Glaucoma? ***Yes / No*** If Yes what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family history of diabetes? ***Yes / No*** If Yes who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activities or hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Deskwork / Typing / Sewing / Reading / TV /Sports***

Do you smoke? ***Yes / No*** Substance abuse? ***Yes / No***

Any further information that may be helpful to the doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Refered by: ***T.V. / Yellow Pages / Insurance / Other\_\_\_\_\_***

***Are you a Yelper? Yes \_\_\_\_ No\_\_\_\_***

Insurance Co.: Medi-Cal VSP Local 770 MES EyeMed Other \_\_\_\_\_\_\_

***Primary Insured Information:***

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_

**Survey Information:**

Preferred Language *(Circle One)*: English Spanish Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Category *(Circle One)*: Hispanic or Latino Native Hawaiian/Other Pacific Islander Not Hispanic or Latino

Race Category *(Circle One)*: American Indian or Alaska Native Asian Black or African American White or Caucassian

Hispanic Native Hawaiian/Other Pacific Islander Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Communication Preference *(Circle One)*: E-mail Postal Telephone **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I HEREBY AUTHORIZE THIS OFFICE TO BE PAID DIRECTLY FOR SERVICES**

**RENDERED FOR MY EYECARE.**

**I UNDERSTAND I AM RESPONSIBLE FOR THE BILL IF MY INSURANCE**

**DOES NOT PAY.**

**SIGNATURE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

We enforce the right to collect twice the amount on all unpaid or returned checks.