To save time, please fill out this form and bring it to your appointment.

Patient Exam Information (Must be updated at each visit)

Today's Date ___________ Please circle: Dr. Mr. Mrs. Ms. Sex: M F SS# (of patient)________-______-__________

First Name ______________________________ MI_______ Last Name ____________________________________

Address ____________________________ City ________________________ State ____________ Zip ____________

Home Phone(____)__________________ Cell Phone(_____)__________________ Work Phone(____)________________

Date of Birth________/________/________ Occupation______________________ Employer_____________________

E-Mail Address____

VISION INSURANCE: **ID#**________________________ ☐**VSP** ☐**EYEMED** ☐**OPTUM HEALTH** ☐**OTHER**

MEDICAL INSURANCE: Name of Plan___________________________ ID Number__________________________

Primary Insured: Last ____________________ First __________________ SS# of Primary_________-_______-_________

Primary Birth Date _____/_____/________ Patient Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

OCULAR HISTORY

What is the reason for today's visit? ____

Age of present glasses______________________________ **Date of last eye exam**___________________________

Have you been examined in our office before? ☐ No ☐ Yes When:________________

Have your eyes been dilated before? ☐ No ☐ Yes When:________________

If you wear contact lenses please answer the following:
Type: ☐ Soft ☐ Rigid ☐ Toric ☐ Multifocal ☐ Monovision Brand: ________________________

Method of wear: ☐ Extended Wear ☐ Daily Wear ☐ Daily Disposable Replacement Frequency:______________

Have you any eye surgery/injuries? ☐ No ☐ Yes If yes, please explain____________________________________

What other services would you like to be evaluated for?
☐ Refractive Surgery ☐ Contact Lenses ☐ Sunglasses
☐ Computer Glasses ☐ Reading Glasses ☐ Driving Glasses

Do you currently, or have you ever had any problems in the following areas?
☐ Distance Blur ☐ Reading Blur ☐ Eyestrain ☐ Halos ☐ Flashes/ Floaters
☐ Distorted Vision ☐ Double Vision ☐ Dryness ☐ Redness
☐ Discharge ☐ Itching ☐ Sandy or Gritty ☐ Burning
☐ Excess tearing/Watering ☐ Eye Pain ☐ Glare/Light Sensitivity ☐ Styes or Chalazion

Which features will be important in choosing your new glasses?
☐ Highest Quality Technology ☐ Highest Definition Vision ☐ Best Value for Money
☐ Least Expensive Option ☐ Image / Style ☐ Durability
☐ Comfort - Light and thin ☐ Lens type ☐ Glare protection
☐ Other ____

If Contact Lenses are indicated, which features are important to you?
☐ Safety ☐ Comfort ☐ Best
Vision Quality
☐ Convenience ☐ Over-night Wear ☐ Color
Enhancement
☐ Cost-effectiveness ☐ Myopia Reduction ☐
Other____________

Do you,or any family members have a history of the following? If yes please check box
☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachment
☐ Other

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Explain____

Are you or could you be pregnant? ☐ No ☐ Yes

(*Please Complete Front and Back of This Form*)

MEDICAL HISTORY

Review of Systems Please check the box beside any problem you currently have, or have had in the following areas

ALLERGIC / IMMUNOLOGIC ☐ All Normal
- ☐ Allergy/ Hay Fever

CARDIOVASCULAR / CARDIAC ☐ All Normal
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

CONSTITUTIONAL ☐ All Normal
- ☐ Fever
- ☐ Weight Loss / Gain

EAR, NOSE, MOUTH, THROAT ☐ All Normal
- ☐ Sinus Congestion
- ☐ Dry Throat/ Mouth

ENDROCRINE ☐ All Normal
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Chronic Fatigue

GASTROINTESTINAL ☐ All Normal
- ☐ Diarrhea / Constipations
- ☐ IBS / Crohn's Disease
- ☐ Ulcers
- ☐ Reflux

GENITOURINARY ☐ All Normal
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

HEMATOLOGIC / LYMPHATIC ☐ All Normal
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

INTEGUMENTARY ☐ All Normal
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising

MUSCULOSKELETAL ☐ All Normal
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain

NEUROLOGICAL ☐ All Normal
- ☐ Migraines
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke

PSYCHIATRIC ☐ All Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations

RESPIRATORY ☐ All Normal
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough

Are you in good health? ☐Yes ☐ No

Any allergic reactions to medications or other substances? ☐ No **If yes , please list** _______________________

Do you take any medication? ☐ No ☐ Yes Please list names and how often_______________________

____

Do you have a history of smoking, alcohol, or substance abuse? ☐ No ☐ Yes Please list_______________________

I certify that the above information given by me in applying for insurance payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Laguna Hills Mall Optometric Center for any services and materials furnished. My signature authorizes release of medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I also agree that any unpaid materials or services are my responsibility.

Patient/Responsible Signature: _______________________ Date: ___________

For Office Use Only: Staff___________ Date:_____________ Time: ___________

Ins. Provider Phone #:_______________________ S/W_______________________

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Medical Coverage:____ Co-Pay per visit:____________________ (Specialist)

Deductible: _____NO ______YES If Yes, Amount: _____________ Amount Met: _____________

Notes: ____ ☐Scanned Insurance Card ☐Insurance Card Not Available