VISALIA VALLEY OPTOMETRIC GROUP

PATIENT INFORMATION AND HISTORY FORM

THANK YOU FOR CHOOSING US FOR YOUR EYE CARE. IN ORDER TO PROVIDE YOU WITH THE BEST CARE POSSIBLE, WE ASK YOU THAT YOU ANSWER THE QUESTIONS BELOW. IF YOU PREFER, WE WILL BE HAPPY TO SIT DOWN WITH YOU TO HELP YOU COMPLETE THIS FORM. WE ARE HERE TO ASSIST YOU!

LAST NAME: _____ FIRST NAME: _____ MI: _____ DATE: _____

SOCIAL SECURITY #: _____ SEX: ☐ M ☐ F DATE OF BIRTH: _____ AGE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED IF MARRIED, SPOUSES NAME: _____

PARENT OR LEGAL GUARDIAN, IF CHILD: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

HOME PHONE: (___) _____ CELL PHONE: (___) _____ WORK PHONE: (___) _____

OCCUPATION: _____ EMPLOYER: _____

INSURANCE INFORMATION :

VISION INSURANCE PLAN(S)? _____

HEALTH INSURANCE PLAN: _____ H.M.O.? ☐ Y (Yes) ☐ N (No)

NAME OF INSURED: _____ MEDICARE? ☐ Y ☐ N MEDI-CAL? ☐ Y ☐ N

NEW PATIENTS: HOW DID YOU HEAR ABOUT US? _____

IF REFERRED, WHOM MAY WE THANK? _____

MEDICAL INFORMATION:

MANY HEALTH CONDITIONS, AS WELL AS MEDICATIONS, CAN HAVE AN IMPACT ON THE HEALTH OF YOUR EYES. PLEASE COMPLETE THE FOLLOWING INFORMATION SO THAT YOUR DOCTOR CAN PROVIDE YOU WITH THE MOST THOROUGH EVALUATION OF YOUR EYE HEALTH. HAVE YOU HAD ANY ONGOING PROBLEMS WITH THE FOLLOWING SYSTEMS? PLEASE CHECK ALL THAT APPLY.

- ☐ gastrointestinal
- ☐ ears/nose/throat
- ☐ cardiovascular/heart disease
- ☐ respiratory/breathing
- ☐ high blood pressure
- ☐ nervous system
- ☐ urinary tract
- ☐ muscles/bones
- ☐ integument/skin
- ☐ cancer
- ☐ endocrine/glands
- ☐ blood/lymph
- ☐ allergic/immunologic
- ☐ headaches
- ☐ psychiatric/psychological
- ☐ other, not listed: _____
- ☐ diabetes (for how long: _____) ☐ type 1 ☐ type 2

PLEASE EXPLAIN ANY OF THE ABOVE:_____

_____

OTHER HEALTH PROBLEMS: _____

DO YOU TAKE ANY MEDICATIONS, INCLUDING NON-PRESCRIPTION AND SUPPLEMENTS? ☐Y ☐N IF YES, PLEASE LIST:

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐Y ☐ N IF YES PLEASE LIST:_____

DO YOU SMOKE? ☐Y ☐ N DO YOU USE ALCOHOL? ☐Y ☐ N DO YOU USE RECREATIONAL DRUGS? ☐Y ☐N

NAME OF PRIMARY CARE DOCTOR: _____ DATE OF LAST VISIT: _____

(PLEASE COMPLETE NEXT PAGE)

FAMILY EYE & MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY TO YOUR IMMEDIATE FAMILY:

PLEASE CHECK (✓) ANY CONDITION have occurred in your immediate family:

- ☐ glaucoma relation: __________
- ☐ macular degeneration relation: __________
- ☐ retinal detachment relation: __________
- ☐ cataracts relation: __________
- ☐ diabetes relation: __________
- ☐ high blood pressure relation: __________

PATIENT'S EYE HISTORY

DATE OF LAST EYE EXAM: ___________ BY WHOM? ____________________________________ DILATED? ☐Y ☐N

DO YOU WEAR GLASSES? ☐Y ☐N DO YOU WEAR CONTACT LENSES? ☐Y ☐ N IF YES: ☐ SOFT ☐ RIGID

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ glaucoma ☐ retinal detachment ☐ dry eyes ☐ cataracts ☐ macular degeneration

DO YOU HAVE ANY OTHER EYE CONDITIONS? IF SO, PLEASE DESCRIBE: ____________________________________

____

HAVE YOU HAD ANY EYE INJURIES OR SURGERY? IF SO PLEASE DESCRIBE: ________________________________

____ DATE(S) OF ABOVE : _________________________

DO YOU USE ANY EYE DROPS (PRESCRIPTION OR OVER-THE-COUNTER)? PLEASE LIST : _________________________

FOR WHAT EYE PROBLEM(S) ARE YOU SEEKING CARE FOR TODAY?: ____

____

CHECK ALL THAT APPLY: ☐ itchy eyes ☐ stinging/burning ☐ flashes/floaters ☐ eyestrain/eye fatigue ☐ blurry vision ☐ eye pain ☐ red eyes

◆◆

IN ORDER TO ASSIST YOU IN PROCESSING YOUR INSURANCE CLAIM AND TO ALLOW FOR COMUNICATION WITH YOUR OTHER HEALTH CARE PROVIDERS, PLEASE READ AND COMPLETE THE FOLLOWING:

INSURANCE AUTHORIZATION:

IF YOUR INSURANCE IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:

POLICY HOLDER'S NAME: ______________________ POLICY HOLDERS DATE OF BIRTH: _____/_____/_________

RELATIONSHIP TO YOU: ______________________ INSURANCE I.D. NO: ________________________________

I AUTHORIZE THIS OFFICE TO BILL MY INSURANCE CARRIER(S) ON MY BEHALF. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO THIS OFFICE FOR ANY SERVICES FURNISHED TO ME AT THIS OFFICE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURRANCE CARRIER(S). A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASED TO MY INSURANCE CARRIER(S) ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE FOR RELATED SERVICES FOR MYSELF AND/OR MY DEPENDENTS.

PATIENT/GUARDIAN SIGNATURE:______________________________

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT:

WE KEEP A RECORD OF THE HEALTHCARE WE PROVIDE YOU. YOU MAY REQ1UEST A COPY OF YOUR MEDICAL RECORD IN WRITING.. WE WILL NOT DISCLOSE YOUR RECORDS TO OTHERS UNLESS YOU DIRECT US TO DO SO, OR UNLESS LEGAL AUTHORITIES COMPEL US TO. ◆◆◆
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FOR DOCTOR'S USE ONLY:

This form was reviewed by: ___________ ___________ ___________ ___________ ___________

1/1/2011 **Date(s):** _________ _________ _________ _________ _________