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: ODr. OMr. OMrs. OMs. Sex: M O F O 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

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 Eye Care Optometry 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_____

Medical Coverage:_____ Co-Pay per visit:_____ (Specialist)

Deductible: _____NO _____YES If Yes, Amount: _____ Amount Met: _____

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