Ocean Ranch OPTOMETRY

Full Name: _____ Preferred Name: _____ Sex: ☐Male ☐Female
Mailing Address: _____ City: _____ State: ____ Zip: _____
Preferred Language_____ Race: _____ Ethnicity: _____ Birth Date: _____
Email Address: _____ Last 4 of SSN: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
What is your preferred method of communication? ☐Email ☐Mail ☐Telephone May we send you text message alerts? ☐Yes ☐No
Employer/ School: _____ Occupation/ Grade: _____
Who may we thank for referring you to our office? _____ If not referred, how did you hear about our office: ☐Insurance ☐Internet ☐Walk-in ☐Location ☐ Doctor: _____ ☐ Other:_____
Emergency Contact: _____ Relationship: _____ Phone Number: _____
What is the reason for today's visit? ☐Red Eye ☐Dry Eye ☐Itchy Eye ☐Blurry Vision ☐Floaters ☐Glasses ☐Contact Lenses ☐ Other

VISION INSURANCE

Insurance Company:_____
ID #: _____
Subscriber: _____
DOB: _____/_____/_____ Last 4 Of SSN #_____
Relationship: ☐Self ☐Spouse ☐Parent/Guardian ☐Other

MEDICAL INSURANCE

Insurance Company: _____
ID #: _____
Subscriber: _____
DOB: _____/_____/_____ Last 4 Of SSN #_____
Relationship: ☐Self ☐Spouse ☐Parent/Guardian ☐Other

OCULAR HISTORY

Date of Last Eye Examination: _____ Previous Eye Doctor: _____

Do you wear glasses? ☐Yes ☐No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐Yes ☐No If yes, what type? ☐Disposable ☐Rigid ☐Soft ☐Toric ☐Multifocal

How often do you discard your contact lenses? ☐Daily ☐Weekly ☐2-3 Weeks ☐Monthly ☐Quarterly

Do you drive? ☐Yes ☐No Do you have difficulty seeing when driving? ☐Yes ☐No

Are there any problems with your current glasses or contact lenses? _____

What other services are you interested in? ☐LASIK ☐Computer Glasses ☐Reading Glasses ☐Prescription Sunglasses ☐Driving Glasses

Please note if you have any of the following:

☐Strabismus (Eye Turn)
☐Diabetic Retinopathy
☐Retinal Detachment
☐Amblyopia (Lazy Eye)
☐Retinal Disease
☐Keratoconus
☐Dry Eye
☐Glaucoma
☐Optic Nerve Disease
☐Macular Degeneration

Have you had surgery for any of the following?

☐Cataract ☐Right Eye ☐Left Eye
☐Retinal Detachment ☐Right Eye ☐Left Eye
☐Trauma ☐Right Eye ☐Left Eye
☐Laser Vision Correction ☐Right Eye ☐Left Eye
☐Other (please list): _____

MEDICAL HISTORY

Please list any medications you are currently taking (including eye drops, oral contraceptives, aspirin, over the counter medications): _____

_____

Are you allergic to any medications? If yes, which ones: _____
List any recent surgeries and/or hospitalizations you have had: _____

_____

FAMILY HISTORY Please note any family history (parents, grandparents, siblings; living or deceased) for the following conditions:

	Relation to You		Relation to You
☐Blindness	_____	☐Cancer	_____
☐Cataracts	_____	☐Diabetes	_____
☐Strabismus (Eye Turn)	_____	☐Heart Diabetes	_____
☐Glaucoma	_____	☐High Blood Pressure	_____
☐Macular Degeneration	_____	☐Kidney Disease	_____
☐Retinal Detachment	_____	☐Lupus	_____
☐Arthritis	_____	☐Thyroid Disease	_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had problems in the following areas:

Eyes (Ocular Symptoms)
- ☐ Eye pain or soreness
- ☐ Fatigue/ Tired Eyes
- ☐ Dry/ Gritty feeling
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Excess Watering
- ☐ Discharge
- ☐ Foreign Body Sensation
- ☐ Chronic Infections
- ☐ Squinting
- ☐ Glare/Light Sensitivity
- ☐ Halos around Lights
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Blurred Vision
- ☐ Flashes
- ☐ Floaters
- ☐ Stye

Cancer
- ☐ Type: _____

Cardiovascular/Vascular
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke

Constitutional
- ☐ Fever
- ☐ Weight Gain or Loss

Ear, Nose, Throat, Mouth
- ☐ Allergies/ Hay Fever
- ☐ Sinus Infections
- ☐ Hearing Loss

Genitourinary
- ☐ Genitals/Kidney/Bladder

Endocrine
- ☐ Thyroid
- ☐ Diabetes
- ☐ Chronic Fatigue
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Lupus

Neurological
- ☐ Headaches
- ☐ Seizures
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Multiple Sclerosis

Gastrointestinal
- ☐ Acid Reflux
- ☐ IBS/ Crohn's Disease
- ☐ Liver/ Spleen Problems
- ☐ Ulcers

Musculoskeletal
- ☐ Rheumatoid arthritis
- ☐ Muscle/Joint Pain

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema

Skin
- ☐ Rosacea
- ☐ Allergic Reactions
- ☐ Easy Bruising

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

ASSIGNMENT AND RELEASE

Please sign below for authorization of payment for contracted insurance plans and the release of any medical information necessary for your insurance company in conjunction with federal privacy laws. Our office will provide you with a thorough receipt for reimbursement of non-contracted insurance plans.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose health information in order to treat you, obtain payment for our services, and conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. **I acknowledge that I have received a copy of the office's Notice of Privacy Practices**

By signing below you acknowledge that you accept responsibility for payment of our services and materials you receive. Payment for professional services is expected at the time services are provided. We accept cash, check, Visa, MasterCard, American Express and Discover. Our policy regarding orders for materials is that we require a minimum of a 50% deposit at the time the order is placed and balance due upon delivery. All professional services are non-refundable. All material returns are subject to a 20% restocking fee.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

☐ EX ☐ CTL EX ☐ CTL CHECK ☐ WEARING CTL ☐ OFFICE VISIT ☐ EMERGENCY OFFICE VISIT

NOTES FOR EXAM:

MEDICARE DEDUCT MET: YES NO

CONTACTS:

CURRENTLY WEARING:

BC: OD:

BC: OS:

TRIAL LENSES:

BC: OD:

BC: OS:

☐ ORDER TRIALS ☐ ORDER CTLS

☐ 1 WK F/U ☐ OTHER _____

GLASSES:

Discussed:

1ST PAIR A/R: ☐ SV: ☐ PROG: ☐ BF: ☐ RX SUN: ☐

2ND PAIR A/R: ☐ SV: ☐ PROG: ☐ BF: ☐ RX SUN: ☐

CRT/ NVF A/R: ☐ SV: ☐ PROG: ☐ BF: ☐

☐ ARMD ☐ GLAUCOMA FOLLOW-UP: _____

☐ DRY EYE ☐ DIABETES

☐ LASIK ☐ BLEPHARITIS MEDICAL INS.: _____

☐ RED EYE ☐ OTHER _____ ☐ DR. SPAETH ☐ BILLING