Ocean Ranch OPTOMETRY

Welcome back! We look forward to helping you with your eye care needs.

Full Name: _____Preferred Name: _____ Birth Date: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Email Address: _____ Cell Phone: _____ May we send you text message alerts? ☐Yes ☐No

What is the reason for today's visit? ☐Red Eye ☐Dry Eye ☐Itchy Eye ☐Blurry Vision ☐Floaters ☐Glasses ☐Contact Lenses ☐ Other

OCULAR HISTORY

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

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

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: _____

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

SOCIAL HISTORY

Do you drive? ☐No ☐Yes If yes, do you have visual difficulty when driving? ☐ No ☐Yes

Do you use tobacco products? ☐No ☐Yes

Do you drink alcohol? ☐No ☐Yes

Do you use illegal drugs? ☐No ☐

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis ☐NONE

MEDICAL HISTORY

Name of Medical Doctor:

_____

Dr.'s Phone: _____Last Medical Exam: _____

Do you have any allergies to medications? ☐No ☐Yes If yes, explain:

_____

List any medications you take (including oral contraceptives, aspirin,

over the counter medications and home remedies): ☐None

_____

List all major injuries, surgeries and/or hospitalizations you have had:

_____

Have you had any of the following? (Check all that apply)

☐Crossed Eyes ☐Lazy Eye ☐Drooping eyelid ☐Prominent Eyes ☐Glaucoma ☐Retinal Disease ☐Cataracts

☐Eye Infections ☐Eye Injury Please Explain: _____

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU				
Arthritis	☐	☐	☐	Self	Mother	Father	Sibling	Other
Blindness	☐	☐	☐	Self	Mother	Father	Sibling	Other
Cancer	☐	☐	☐	Self	Mother	Father	Sibling	Other
Cataract	☐	☐	☐	Self	Mother	Father	Sibling	Other
Crossed Eyes	☐	☐	☐	Self	Mother	Father	Sibling	Other
Diabetes	☐	☐	☐	Self	Mother	Father	Sibling	Other
Eye Muscle Surgery	☐	☐	☐	Self	Mother	Father	Sibling	Other
Glaucoma	☐	☐	☐	Self	Mother	Father	Sibling	Other
Heart Disease	☐	☐	☐	Self	Mother	Father	Sibling	Other
High Blood Pressure	☐	☐	☐	Self	Mother	Father	Sibling	Other
HIV	☐	☐	☐	Self	Mother	Father	Sibling	Other
Keratoconus	☐	☐	☐	Self	Mother	Father	Sibling	Other
Kidney Disease	☐	☐	☐	Self	Mother	Father	Sibling	Other
Laser Correction	☐	☐	☐	Self	Mother	Father	Sibling	Other
Lupus	☐	☐	☐	Self	Mother	Father	Sibling	Other
Macular Degeneration	☐	☐	☐	Self	Mother	Father	Sibling	Other
Multiple Sclerosis	☐	☐	☐	Self	Mother	Father	Sibling	Other
Refractive Surgery	☐	☐	☐	Self	Mother	Father	Sibling	Other
Retinal Detachment/Disease	☐	☐	☐	Self	Mother	Father	Sibling	Other
STDs	☐	☐	☐	Self	Mother	Father	Sibling	Other
Stroke	☐	☐	☐	Self	Mother	Father	Sibling	Other
Thyroid Disease	☐	☐	☐	Self	Mother	Father	Sibling	Other
Tuberculosis	☐	☐	☐	Self	Mother	Father	Sibling	Other

	SYSTEM	YES	NO	?
CONSTITUTIONAL	FEVER, WEIGHT LOSS/GAIN	☐	☐	☐
	INTEGUMENTARY (SKIN)	☐	☐	☐
NEUROLOGICAL	HEADACHES	☐	☐	☐
	MIGRAINES	☐	☐	☐
	SEIZURES	☐	☐	☐
EARS,	ALLERGIES/HAY FEVER	☐	☐	☐
NOSE,	SINUS CONGESTION	☐	☐	☐
MOUTH & THROAT	RUNNY NOSE	☐	☐	☐
	POST-NASAL DRIP	☐	☐	☐
	CHRONIC COUGH	☐	☐	☐
	DRY THROAT/MOUTH	☐	☐	☐
RESPIRATORY	ASTHMA	☐	☐	☐
	CHRONIC BRONCHITIS	☐	☐	☐
	EMPHYSEMA	☐	☐	☐
ENDOCRINE	THYROID/OTHER GLANDS	☐	☐	☐
EYES	LOSS OF VISION	☐	☐	☐
	BLURRED VISION	☐	☐	☐
	DISTORTED VISION/HALOS	☐	☐	☐
	LOSS OF SIDE VISION	☐	☐	☐
	DOUBLE VISION	☐	☐	☐
	DRYNESS	☐	☐	☐
	MUCOUS DISCHARGE	☐	☐	☐
	REDNESS	☐	☐	☐
	SANDY OR GRITTY FEELING	☐	☐	☐
	ITCHING	☐	☐	☐
	BURNING	☐	☐	☐
	FOREIGN BODY SENSATION	☐	☐	☐
	EXCESS TEARING/WATERING	☐	☐	☐
	GLARE/LIGHT SENSITIVITY	☐	☐	☐
	EYE PAIN OR SORENESS	☐	☐	☐
	CHRONIC INFECTION OF EYE OR LID	☐	☐	☐
	STIES OR CHALAZION	☐	☐	☐
	FLASHES/FLOATERS IN VISION	☐	☐	☐
	TIRED EYES	☐	☐	☐
VASCULAR/	DIABETES	☐	☐	☐
CARDIOVASCULAR	HEART PAIN	☐	☐	☐
	HIGH BLOOD PRESSURE	☐	☐	☐
	VASCULAR DISEASE	☐	☐	☐
GASTROINTOUINARY	GENITALS/KIDNEY/BLADDER	☐	☐	☐
BONES/	RHEUMATOID ARTHRITIS	☐	☐	☐
JOINTS/	MUSCLE PAIN	☐	☐	☐
MUSCLES	JOINT PAIN	☐	☐	☐

MEDICAL HX & ROS FROM: _____ reviewed

☐ NO CHANGES _____Initials