**WELCOME TO OUR OFFICE**

 **DateToday**  **Appointment:**

 **Name:** **DOB:** **Age: \_\_\_\_\_\_\_**

 **Address**:

 **City/Zip:**

 **Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_

 **Email**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Texting Ok

 **Driver's License:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Exp. Date:\_*\_\_\_\_\_\_ **Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Marital Status:** *Single / Married / Divorced / Widowed*

 **Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employment Status:** *Full Time / Part Time / Student / Unemployed*

 Have you been here before? ***Yes / No*** Last Exam Date: \_\_\_\_\_\_\_\_\_\_

 Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Reason for this exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Are you currently wearing glasses*? ­\_\_\_\_ *Contact Lenses*?\_\_\_\_

 *Are you interested in contact lenses*?\_\_\_\_*Are you interested in corrective laser eye surgery*?\_\_\_\_

 How many hours a day do you spend at the computer? \_\_\_\_\_\_\_\_

 **Please indicate any of the following that apply to you:**

 \_\_\_ High Blood Pressure \_\_\_ Eyes Water \_\_\_Blur at Distance

 \_\_\_ Heart Trouble \_\_\_ Eyes Itch \_\_\_Blur Near

 \_\_\_ Diabetes \_\_\_ Eye Strain \_\_\_Blur After Reading

 \_\_\_ Thyroid \_\_\_ Eye Fatigue \_\_\_Difficulty Re-Focusing

 \_\_\_ Lupus \_\_\_ Eye Injury \_\_\_Double Vision

 \_\_\_ Rheumatoid Arthritis \_\_\_ Eye Surgery \_\_\_Headache

 \_\_\_ Asthma \_\_\_ Eye Disease \_\_\_Dry Eyes

 \_\_\_ Emphysema \_\_\_ Color Blindness \_\_\_Skip Words

 \_\_\_ Glaucoma \_\_\_ Seeing Spots \_\_\_Reading Problems

 \_\_\_ Seasonal Allergies \_\_\_ Light Flashes \_\_\_Difficulty Driving at Night

 \_\_\_ Pregnancy mo \_\_\_\_ \_\_\_ Sensitive to Light \_\_\_Bothered by Glare

 Medications used at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you allergic to any medications? ***Yes / No*** If Yes to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family History of Eye Disease or Glaucoma? ***Yes / No*** If Yes what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family history of diabetes? ***Yes / No*** If Yes who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Activities or hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Deskwork / Typing / Sewing / Reading / TV /Sports***

 Do you smoke? ***Yes / No*** Substance abuse? ***Yes / No***

 Any further information that may be helpful to the doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Refered by: ***T.V. / Yellow Pages / Insurance / Other\_\_\_\_\_***

 ***Are you a Yelper? Yes \_\_\_\_ No\_\_\_\_***

 Insurance Co.: Medi-Cal VSP Local 770 MES EyeMed Other \_\_\_\_\_\_\_

 ***Primary Insured Information:***

 Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_

**Survey Information:**

Preferred Language *(Circle One)*: English Spanish Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Category *(Circle One)*: Hispanic or Latino Native Hawaiian/Other Pacific Islander Not Hispanic or Latino

Race Category *(Circle One)*: American Indian or Alaska Native Asian Black or African American White or Caucassian

 Hispanic Native Hawaiian/Other Pacific Islander Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Communication Preference *(Circle One)*: E-mail Postal Telephone **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **I HEREBY AUTHORIZE THIS OFFICE TO BE PAID DIRECTLY FOR SERVICES**

 **RENDERED FOR MY EYECARE.**

 **I UNDERSTAND I AM RESPONSIBLE FOR THE BILL IF MY INSURANCE**

 **DOES NOT PAY.**

 **SIGNATURE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **PRINT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

We enforce the right to collect twice the amount on all unpaid or returned checks.