Welcome to Westside Optometry

PERSONAL INFORMATION

Name_____Date_____

[ ]Mr.[ ]Mrs.[ ]Ms. [ ]Dr. [ ] Miss. [ ] Rev. If child, parent's name?_____

Street_____City_____

Zip_____Home Phone_____Work Phone_____

Birthdate_____ Social Security Number_____

Cell#_____Email_____

Occupation_____Employer_____

Hobbies/Sports_____

How did you hear about us? [ ] Insurance [ ] Yellow Pages [ ] Newspaper [ ] Newsletter [ ]Other [ ] Family/Friend?

Who?_____

OCULAR HISTORY

Concerns or problems with your eyes_____

Are you interested in glasses today? _____Contact Lenses? _____LASIK? _____

Last Eye Exam_____From Dr._____Results_____

Last Physical Exam_____ _From Dr._____Results_____

Do you wear Contact Lenses now?_____(if "yes" mark all that apply)

[ ]soft [ ]gas permeable [ ]monovision [ ] bifocal [ ] extended wear [ ]other?_____

Explain any eye injuries and/or surgeries _____

HEALTH HISTORY

Do you have any allergies to medications?_____To what?_____

List any medications you are presently taking (including oral contraceptives, aspirin, over-the-counter drugs and natural remedies)_____

_____

List all major injuries and surgeries and/or hospitalizations you have had_____

_____

FAMILY HISTORY

Family history unknown, I'm adopted[ ]

Please note any family history (parents, grandparents, siblings, children, living or deceased)

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	[ ]	[ ]	[ ]	_____
Cataract	[ ]	[ ]	[ ]	_____
Crossed Eyes	[ ]	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	[ ]	_____
Macular Degeneration	[ ]	[ ]	[ ]	_____
Retinal Detachment/Disease	[ ]	[ ]	[ ]	_____
Arthritis	[ ]	[ ]	[ ]	_____
Cancer	[ ]	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	[ ]	_____
Heart Disease	[ ]	[ ]	[ ]	_____
High Blood Pressure	[ ]	[ ]	[ ]	_____
Kidney Disease	[ ]	[ ]	[ ]	_____
Lupus	[ ]	[ ]	[ ]	_____
Thyroid Disease	[ ]	[ ]	[ ]	_____
Other_____				

Please turn this form over and complete the other side

FINANCIAL POLICY

We provide the highest quality eye and vision care for our patients. In return for our uncompromising standards and service, we ask that our patients keep their accounts current. Please read, initial and sign the following FINANCIAL POLICY. If you have any questions please feel free to ask us.

Patients are expected to pay in full at the time services are rendered, and pay at least 50% towards material fees when ordered. The balance is due upon delivery of the product(s). We accept cash, checks, Visa and MasterCard. After 30 days, account balances are considered delinquent and subject to a billing charge. There is a $10 fee for returned checks. _____
Initial

INSURANCE INFORMATION

As a courtesy to our patients we accept assignment for Vision Service Plan, Medi-Cal, Medicare, Vision Care Plan and Safeguard. Copayments, deductibles and charges not covered by these plans are the patient's responsibility.

What is your vision plan? [ ]None [ ]VSP [ ]Medicare [ ]Medi-Cal [ ]VCP [ ]Safeguard [ ]Other_____

Subscriber's Name_____ Subscriber's Birthdate_____

Subscriber's Social Security Number_____

What is your medical insurance?_____ Primary Care Physician_____

If you notify us after services are rendered and materials ordered that you have vision insurance, we will supply you with a coded receipt that you can submit to receive reimbursement directly from your plan. However, be aware that your insurance company may only send you a partial reimbursement of the fees you paid.

I have read, understand and agree to the above financial policy for payment of professional services and product fees.

_____

Responsible person's signature or parent if minor Date

SIGNATURE ON FILE (PLEASE COMPLETE IF YOU HAVE VISION INSURANCE)

I certify that the information given to me in applying for payment under title XVII of the Social Security Act is correct.

I authorize use of this form on all my insurance submissions.
I authorize release of information to all my insurance companies.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I permit a copy of this authorization to be used in place of the original.

_____

Beneficiary or Guardian's Signature Date

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPA)

HIPPA is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by HIPPA, we have prepared a NOTICE OF PRIVACY PRACTICES POLICY. This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request and on our website. _____
Initial

We appreciate the opportunity to serve you, your family and your friends. Our commitment is to provide you with the highest quality service and products. Thank you for your attention in providing us the above information.

Name _____ Date _____

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. [ ] Yes, I would prefer to discuss my Social History information directly with the doctor.*

Do you drive? Yes [ ] No [ ] If yes, do you have visual difficulties? Yes [ ] No [ ] If yes, please describe:
_____
Do you use tobacco products? Yes [ ] No [ ] If yes, type, amount and how long? _____
Do you drink alcohol? Yes [ ] No [ ] If yes, type, amount and how often? _____
Do you use illegal drugs? Yes [ ] No [ ] If yes, type, amount and how often? _____

REVIEW OF SYSTEM
Do you currently have any problems in the following areas:

SYSTEM	NO	YES	?
Constitutional			
Fever, Weight Loss/Gain	[ ]	[ ]	[ ]
Integumentary (Skin)	[ ]	[ ]	[ ]
Neurological			
Headache	[ ]	[ ]	[ ]
Migraine	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]
Eyes			
Loss of Vision	[ ]	[ ]	[ ]
Blurred Vision	[ ]	[ ]	[ ]
Distorted Vision/Haloes	[ ]	[ ]	[ ]
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 Eye Infection	[ ]	[ ]	[ ]
Sties or Chalazion	[ ]	[ ]	[ ]
Flashes/Floaters in Vision	[ ]	[ ]	[ ]
Tired Eyes	[ ]	[ ]	[ ]
Endocrine			
Thyroid/Other Glands	[ ]	[ ]	[ ]

	NO	YES	?
Ear, Nose, Mouth and Throat			
Allergies/Hayfever	[ ]	[ ]	[ ]
Sinus Congestion	[ ]	[ ]	[ ]
Runny Nose	[ ]	[ ]	[ ]
Post-Nasal Drip	[ ]	[ ]	[ ]
Chronic Cough	[ ]	[ ]	[ ]
Dry Throat/Mouth	[ ]	[ ]	[ ]
Respiratory			
Asthma	[ ]	[ ]	[ ]
Chronic Bronchitis	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]
Vascular/Cardiovascular			
Diabetes	[ ]	[ ]	[ ]
Heart Pain	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]
Vascular Disease	[ ]	[ ]	[ ]
Gastrointestinal			
Diarrhea	[ ]	[ ]	[ ]
Constipation	[ ]	[ ]	[ ]
Genitourinary			
Genitals/Kidney/Bladder	[ ]	[ ]	[ ]
Bones/Joints/Muscles			
Rheumatoid Arthritis	[ ]	[ ]	[ ]
Muscle Pain	[ ]	[ ]	[ ]
Joint Pain	[ ]	[ ]	[ ]
Lymphatic/Hematologic			
Anemia	[ ]	[ ]	[ ]
Bleeding Problems	[ ]	[ ]	[ ]
Allergic/Immunologic	[ ]	[ ]	[ ]
Psychiatric	[ ]	[ ]	[ ]

If you answered YES to any of the above or have a condition not listed, please explain below:

_____
_____
_____
_____
_____

_____ _____
Doctor's Signature Date