Welcome to Westside Optometry

PERSONAL INFORMATION

Name_____ Nickname _____Date_____

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

Preferred Method of Contact? Cell Home Work Email

Street_____City_____

Zip_____Home Phone_____ Work Phone_____

Birthdate_____ Social Security Number_____

Cell#_____Email_____

Would you like to receive our newsletter and practice announcements? Y N

Occupation_____Employer_____

Hobbies/Sports_____

Primary Language _____

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, Decline to Specify

Ethnicity: Not Hispanic or Latino, Hispanic or Latino, Decline to Specify

How did you hear about us? [ ] Insurance [ ] Internet [ ] 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 _____

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
Glaucoma	[ ]	[ ]	[ ]	_____
Cataracts	[ ]	[ ]	[ ]	_____
Macular Degeneration	[ ]	[ ]	[ ]	_____
Eye Injury	[ ]	[ ]	[ ]	_____
Retinal Detachment/Disease	[ ]	[ ]	[ ]	_____
Other Eye Disease	[ ]	[ ]	[ ]	_____
Blindness	[ ]	[ ]	[ ]	_____
Strabismus	[ ]	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	[ ]	_____
Cancer	[ ]	[ ]	[ ]	_____
Heart Disease	[ ]	[ ]	[ ]	_____
Kidney Disease	[ ]	[ ]	[ ]	_____
Thyroid Disease	[ ]	[ ]	[ ]	_____

Other_____

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.

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

INSURANCE INFORMATION

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

What is your vision plan? [ ] None [ ]VSP [ ]Medicare [ ]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.

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 (HIPAA)
HIPAA 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 HIPAA, 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? _____

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_____
_____

REVIEW OF SYSTEM

Do you currently have any problems in the following areas:

SYSTEM	**NO**	**YES**	**?**		**NO**	**YES**	**?**
Constitutional				**Ear, Nose, Mouth and Throat**			
Fever, Weight Loss/Gain	[ ]	[ ]	[ ]	Allergies/Hayfever	[ ]	[ ]	[ ]
Integumentary (Skin)	[ ]	[ ]	[ ]	Sinus Congestion	[ ]	[ ]	[ ]
Neurologica Headache	[ ]	[ ]	[ ]	Post-Nasal Drip	[ ]	[ ]	[ ]
Migraine	[ ]	[ ]	[ ]	Chronic Cough	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]	Dry Throat/Mouth	[ ]	[ ]	[ ]
Eyes				**Respiratory**			
Loss of Vision	[ ]	[ ]	[ ]	Sleep Apnea	[ ]	[ ]	[ ]
				Asthma	[ ]	[ ]	[ ]
Blurred Vision	[ ]	[ ]	[ ]	Chronic Bronchitis	[ ]	[ ]	[ ]
Distorted Vision/Haloes	[ ]	[ ]	[ ]	Emphysema	[ ]	[ ]	[ ]
Loss of Side Vision	[ ]	[ ]	[ ]	**Vascular/Cardiovascular**			
Double Vision	[ ]	[ ]	[ ]	Diabetes	[ ]	[ ]	[ ]
Dryness	[ ]	[ ]	[ ]	Heart Pain	[ ]	[ ]	[ ]
Mucous Discharge	[ ]	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	[ ]
Redness	[ ]	[ ]	[ ]	Vascular Disease	[ ]	[ ]	[ ]
Sandy or Gritty Feeling	[ ]	[ ]	[ ]	**Gastrointestinal**			
Itching	[ ]	[ ]	[ ]	Diarrhea	[ ]	[ ]	[ ]
Burning	[ ]	[ ]	[ ]	Constipation	[ ]	[ ]	[ ]
Foreign Body Sensation	[ ]	[ ]	[ ]	**Genitourinary**			
Excess Tearing/Watering	[ ]	[ ]	[ ]	Genitals/Kidney/Bladder	[ ]	[ ]	[ ]
Glare/Light Sensitivity	[ ]	[ ]	[ ]	**Bones/Joints/Muscles**			
Eye Pain or Soreness	[ ]	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	[ ]
Chronic Eye Infection	[ ]	[ ]	[ ]	Muscle Pain	[ ]	[ ]	[ ]
Sties or Chalazion	[ ]	[ ]	[ ]	Joint Pain	[ ]	[ ]	[ ]
Flashes/Floaters in Vision	[ ]	[ ]	[ ]	**Lymphatic/Hematologic**			
Tired Eyes	[ ]	[ ]	[ ]	Anemia	[ ]	[ ]	[ ]
Endocrine				Bleeding Problems	[ ]	[ ]	[ ]
Thyroid/Other Glands	[ ]	[ ]	[ ]	**Allergic/Immunologic**	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	**Psychiatric**	[ ]	[ ]	[ ]

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

_____
_____

_____ _____
Doctor's Signature Date