WELCOME TO SOLANA BEACH FAMILY OPTOMETRY

Personal Information

Last Name_____ First Name_____ M.I._____
Name you preferred to be called_____ Date of Birth_____ Age_____
Title: [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Dr. Gender: [ ] Male [ ] Female
Is the patient under the age of 18? _____ Marital Status_____
Street Address_____ City_____ State/Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Fax Number_____
E-mail_____ Name of Spouse (if applicable)_____
Occupation_____ Employer_____
Social Security # (required if we are to bill your insurance)_____
How did you hear about our office?_____

Insurance Information

Name of Insurance Company for vision care_____
Policy Holder Name_____ Policy Holder Birthdate_____
Policy Holder Social Security #_____ Name of Employer_____
Employer Address_____
Work Phone_____
Medical Insurance_____ Same Policy Holder as above? [ ]Yes [ ]No
If different policy holder, then Name_____ Birthdate_____
Social Security #_____ Work Phone_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: By signing this form below, I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Solana Beach Eyecare, unless payment is made in full at the time of service. I also understand that it may be necessary for me to bill my own insurance company directly if this office is a non-contracted provider.

Financial Responsibility

Your signature on this form acknowledges that you, the patient, agree to bear full responsibility for all services provided if:

1. It is determined that you are not eligible for insurance coverage.
2. The services are not covered under you benefit plan or we were not made aware of you coverage at the time of services.
3. The services have not been referred and/or authorized as required by your health plan.
4. You are seeking services “out of network” with a non-contracted provider.

If an order for glasses or contact lenses is placed by phone, a credit card number is required at the time the order is placed to pay for desired materials. All charges are due and payable at the time of service unless otherwise specified by an insurance company contracted with us.

I have read and understand the above stated office policies. By signing this form, I agree to comply with these policies.

Signature of patient/responsible party_____ Date_____

SOLANA BEACH FAMILY OPTOMETRY

Medical History

Current medications (Include any over the counter medications, eyedrops, and oral contraceptives)_____

_____

Do you have any allergies to medications? [ ] No [ ] Yes If yes, please list:_____

Do you have any environmental allergies, such as hayfever? [ ] No [ ] Yes

Have you ever had any eye injuries or surgeries? [ ] No [ ] Yes If yes, please list:_____

List all major injuries or surgeries you have had (not eye related):_____

_____

For women, are you pregnant or nursing? [ ] No [ ] Yes Do you smoke? [ ] No [ ] Yes

Please note any family history (parents, grandparents, siblings, or children) with the following conditions:

DISEASE/CONDITION	NO	YES	YOURSELF	RELATION OF RELATIVE TO YOU
Blindness	[ ]	[ ]	[ ]	
Cataract	[ ]	[ ]	[ ]	
Crossed eyes or Amblyopia	[ ]	[ ]	[ ]	
Glaucoma	[ ]	[ ]	[ ]	
Macular Degeneration	[ ]	[ ]	[ ]	
Retinal Detachment/Diseases	[ ]	[ ]	[ ]	
Arthritis	[ ]	[ ]	[ ]	
Cancer	[ ]	[ ]	[ ]	
Diabetes	[ ]	[ ]	[ ]	
Heart Disease	[ ]	[ ]	[ ]	
High Blood Pressure	[ ]	[ ]	[ ]	
Kidney Disease	[ ]	[ ]	[ ]	
Lupus	[ ]	[ ]	[ ]	
Thyroid Disease	[ ]	[ ]	[ ]	
Other	[ ]	[ ]	[ ]	

Vision History

Please check which of the following apply:

[ ] I have never worn glasses. [ ] I wear glasses now. [ ] I used to wear glasses.

[ ] I am interested in refractive surgery (LASIK, PRK, etc.)

Are you interested in contact lenses? [ ] No [ ] Yes Do you currently wear contact lenses: [ ] No [ ] Yes

If so, please check the type of contact lenses that you wear:

[ ] Hard or gas permeable

[ ] Soft contact lenses: Which type? [ ] Conventional (yearly replacement)

[ ] Disposable: Daily/2 week/ Monthly/Quarterly (please circle)

Are you wearing your lenses today? [ ] No [ ] Yes If not, when did you last wear them?_____

How often do you change your contact lenses?_____Do you sleep overnight in them? [ ] No [ ] Yes

Do you have any of the following symptoms?

Blurred vision with current prescription glasses or contact lenses at: Far / Intermediate / Near (please circle)

[ ] Discomfort working on computer [ ] Headaches [ ] Dry eyes

[ ] Red, irritated, or painful eyes [ ] Eyes turn in or out [ ] Double vision

I have read and/or received a copy of Solana Beach Eyecare's Notice of Privacy Practices.

Signature:_____ Date:_____