

# WELCOME TO SEAL BEACH EYES!

## PATIENT INFO

Mr.  Mrs.  Ms. Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Other/Cell \_\_\_\_\_  
 SSN \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female  
 Martial Status:  Single  Married  Divorced  Widowed  Other Spouse's Name \_\_\_\_\_  
 Employment:  Full-Time  Part-Time Occupation \_\_\_\_\_ Company \_\_\_\_\_  
 Education:  Full-Time Student  Part-Time Student Email \_\_\_\_\_

## MEDICAL HISTORY

**Name of Family Doctor** \_\_\_\_\_ **Date of Last Visit** \_\_\_\_\_  

	Yes	No	
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Cigarettes/Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	

**Current Medications (including eye drops)**  None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>Allergies</b> <input type="checkbox"/> None	<b>Medication Allergies</b> <input type="checkbox"/> None
_____	_____
_____	_____

	Yes	No		Yes	No	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Family/Relation: _____	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration
Diabetes (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
Operations/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Explain/Date _____			
Other Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	Additional Info _____			

## PERSONAL EYE INFORMATION

**Name of Previous Doctor** \_\_\_\_\_ **Date of Last Exam** \_\_\_\_\_  

	Yes	No	
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Floaters or Spots	<input type="checkbox"/>	<input type="checkbox"/>	
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Itchy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Watering Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Other eye condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Any Eye Operation	<input type="checkbox"/>	<input type="checkbox"/>	Explain/Date _____
Any Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Explain/Date _____
Additional Information			_____

Glasses  None  Reading  Distance  Computer

Bifocals (Line)  Trifocals  Progressives (No-Line)

Contact Lenses \_\_\_\_\_ Hours/Day \_\_\_\_\_

Soft Lenses/Disposables  RGP  Conventional

Type/Brand \_\_\_\_\_ BC \_\_\_\_\_ DIA \_\_\_\_\_

## INSURANCE

Insurance Name _____ ID# _____ Subscriber _____ Date of Birth _____ <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse	Insurance Name _____ ID# _____ Subscriber _____ Date of Birth _____ <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse
<b>ASSIGNMENT AND RELEASE</b>	
<i>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</i> I hereby authorize this vision care provider to apply for benefits on my behalf for covered services rendered and request that all payments be made directly to the vision care provider. I agree to assume all responsibility of full charges whether or not paid by insurance. I further authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.	
X _____	_____
<b>Responsible Party Signature</b>	<b>Date</b>

**Health Insurance Portability and Accessibility Act – ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICE**

It is often necessary to use and disclose health information that identifies you in order to treat you, to obtain payment for our services, and, to conduct healthcare operations involving our office. The Notice of Privacy Practices describes these uses and disclosures in detail. Our office is in full compliant with HIPAA, and a copy of the Notice of Privacy Practice is available if you'd like a copy for your records.

**SIGNATURE X** \_\_\_\_\_ **Date** \_\_\_\_\_

How did you hear about our office?  Insurance List  Local Internet Search  Referred by \_\_\_\_\_