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	☐	☐
Ears/Nose/Throat	☐	☐
Heart disease	☐	☐
Asthma	☐	☐
Thyroid Condition	☐	☐
Kidney Disease	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Headaches	☐	☐
Cigarettes/Tobacco	☐	☐
Alcohol	☐	☐
Pregnant	☐	☐

Current Medications (including eye drops) ☐ None
_____
_____
_____

Allergies ☐ None
_____
_____
_____

Medication Allergies ☐ None
_____
_____
_____

	Yes	No	Family/Relation:		Yes	No	Family/Relation:
High Blood Pressure	☐	☐	☐ _____	Retinal Detachment	☐	☐	☐ _____
Cataracts	☐	☐	☐ _____	Macular Degeneration	☐	☐	☐ _____
Diabetes (Type ____)	☐	☐	☐ _____	Glaucoma	☐	☐	☐ _____
Operations/Surgery	☐	☐	Explain/Date _____				
Other Health Problems	☐	☐	Additional Info _____				

PERSONAL EYE INFORMATION

Name of Previous Doctor_____ **Date of Last Exam**_____

	Yes	No	
Dry Eyes	☐	☐	
Blurred Vision	☐	☐	
Floaters or Spots	☐	☐	
Double Vision	☐	☐	
Itchy Eyes	☐	☐	
Watering Eyes	☐	☐	
Other eye condition(s)	☐	☐	
Any Eye Operation	☐	☐	Explain/Date _____
Any Eye Injury	☐	☐	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

VISION PLAN _____
ID# _____
Subscriber _____
Date of Birth _____ ☐ Self ☐ Parent ☐ Spouse

MEDICAL PLAN _____
ID# _____
Subscriber _____
Date of Birth _____ ☐ Self ☐ Parent ☐ Spouse

ASSIGNMENT AND RELEASE

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE 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_____ _____
Responsible Party Signature **Date**

Health **I**nsurance **P**ortability and **A**ccessibility **A**ct **– 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 _____

www.sealbeacheyes.com 562 431-2031