Patient Information

Today's Date: ________________

Check One: □Mr . □ Ms. □ Miss □ Mrs. □ Dr. □ Minor {Parent's name}_________________________________

Name: ____ Date of Birth: _______________________

Address: ____ SSN: _____________________________

City/Zip: ____ Cell Phone: ____________________ Text? Y/N

E-mail: ____ Home Phone: _______________________

Employer: ______________________ Occupation: _________________ Work Phone:____________________

Race:

☐ Hispanic/Latino ☐ Alaska Native ☐ White American ☐ Asian

☐ Native American ☐ Hawaiian/Pacific Islander ☐ Black/African American ☐ Other:_____________________

Name of Vision Insurance: ☐ VSP ☐ MES ☐ Eyemed ☐ Medi-Care ☐ None ☐ Other __________________________

Name of Primary Medical Insurance: _________________________________ ID#: ________________________

Group No. __________________ Member Name: ___________________________ DOB: __________________

Primary Care physician: ____________________________________ Phone #: ______________________________

Hobbies, special vision needs: ____

I wear glasses: □ yes □ no I have had laser corrective surgery: □ yes □ no Interested in Lasik: □ yes □ no

I wear contact lenses: □ yes □ no Type: __________________ Interested in Contacts: _____________________

When was your last eye exam? __________________ Name of previous eye Dr. _______________________________

Referred by: _____________________________ □ Doctor □ Friend □Family □ Insurance Co. □ Yelp

Due to the Health Insurance Portability and Accountability Act your initials & signature are required below

Initials:

_____ I ***authorize*** any holder of medical information about me to release and/ or request my medical information with other health care Professionals, for the purpose of consultation and referral as appropriate for my health care.

_____ I have been provided the ***Flores Optometry Inc. Privacy Policy***. (You may request a copy for your records.)

AND/ EITHER

_____ I ***authorize*** any holder of medical information about me to release to my insurance company or its agent any information needed to determine these benefits payable for related services. I request that payment of authorized services be made on my behalf to Flores Optometry Inc. I agree to be personally and fully responsible for co-pays, deductibles, non-covered and denied services by my insurance.

_____ I ***decline*** the above information release and am solely responsible for fees. I understand that fees are due at time of service.

Signature: ____________________________________ Relationship to Patient (if minor): ______________________

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Flores Optometry Inc.

GENERAL HEALTH INFORMATION SHEET

PATIENT NAME: ________________________________ DATE: ______________________

Please list any medications:____

____

Please list any allergies (medical & general): ____

____

Do any of the following conditions apply to you:

___Blurred vision ___Lazy eye or eye turn ___Thyroid

___Flashes/ Floaters in vision ___Tired eyes ___Stomach or gastrointestinal

___Cataracts ___Macular degeneration ___Blood disorders

___Dry eye ___Retinal Detachment ___Skin condition

___Redness ___Glaucoma ___Arthritis or joint pain

___Sandy or gritty feeling ___Heart condition/ disease ___Multiple sclerosis

___Itching ___Stroke ___Psychological

___Burning ___High cholesterol ___Asthma (bronchitis, emphysema)

___Foreign body sensation ___High blood pressure ___Cancer

___Excess tearing/ watering ___Diabetes ___Ear/ Nose/ Mouth/ Throat

___Glare/ Light sensitivity ___ Kidney or Liver ___Pregnant

___Eye pain or soreness ___Headaches (migraines, sinusitis)

___Chronic infection of eye ___Constitutional (fever, weight change)

___Tobacco:___light___mod___heavy ___Alcohol: ___light___mod___heavy ___Drug use:___light___mod___heavy

Have you ever been exposed to or infected with: ___Gonorrhea ___Hepatitis ___HIV ___Syphilis

If you indicated any of the above conditions apply to you, please explain the list treatment:

Please list any other health conditions:____

____

Does your family history include any of the following? If yes, what is their relationship to you?

Relationship | Relationship

___Glaucma ____________________________ ___High Blood Pressure ____________________________

___Cataracts ____________________________ ___Heart Disease ____________________________

___Macular Degeneration ________________ ___Diabetes ____________________________

___Retinal Detachment ___________________ ___Thyroid Condition____________________________

___Blindness ____________________________ ___Other ____________________________

Signature: ____ Relationship to Patient: ___________________________

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