Eye Health Optometry
Patient Health and Vision History
(Please Print)

PATIENT INFORMATION

Last Name _____

First Name _____ MI _____

Date of Birth ____/____/____ Age _____
MM / DD / YYYY

Sex ☐ M ☐ F Women: Check if Pregnant or Nursing ☐

Address _____

_____

City _____ State ____ ZIP _____

Please Check Box Next to Preferred Contact Method Below

Home Phone (____) _____ ☐

Work Phone (____) _____ ☐

Cell Phone (____) _____ ☐

E-Mail _____ ☐

SOCIAL HISTORY

Employer

_____

Occupation or Field of Study & School

_____

Hobbies, Artistic Interests & Sports

_____

_____

Other Significant Activities that may impact eye health? Explain.

_____

_____

Reason(s) For Visit

Exam

Date of Last Exam: ____/____/____
MM / DD / YYYY

Previous Eye Doctor, Location

_____

Have you had your eyes dilated before?

☐ Yes, about _____ months ago.

☐ No

I have problems with:

☐ Distance Blur ☐ Headaches

☐ Near/Reading Blur ☐ Computer Vision

☐ Double-Vision ☐ Need New Rx

Glasses

Age of current Glasses:

_____

My glasses are:

☐ Lost

☐ Broken (frame)

☐ Scratched (lenses)

☐ Missing a Lens

☐ Not Effective

☐ I am new to glasses

Contacts

Age of current Contacts:

_____

Select all that apply:

☐ I have *never* worn contacts

☐ Current contacts irritate my eyes

☐ Current contacts are ineffective

☐ Contacts are torn, damaged, or lost

☐ I already wear contacts

- What brand/type?

_____

_____

Medical History

List any **medical conditions** you are currently being treated for: _____

List any **drugs or medications** you are currently taking: _____

List any food, drug, or general **allergies**: _____

List any **past eye injuries or surgeries**: _____

Who is your **Primary Care Physician**? _____

Family Health History (Mark and indicate relation of person with condition):

☐ Diabetes _____

☐ High Blood Pressure _____

☐ Thyroid Problems _____

☐ Heart Disease _____

☐ Lung Disease _____

☐ Cataracts _____

☐ Glaucoma _____

☐ Macular Degeneration _____

☐ Cross/Turned/Lazy Eye _____

☐ Retinal Detachment _____

☐ Eye Disease or Injury _____

☐ Eye Surgery _____

☐ Arthritis _____

☐ Head Injury _____

☐ Other _____

Eye Health Optometry

Patient Insurance, Responsibility statement and Notice of Privacy Practices

Insurance Information

VISION INSURANCE

☐ VSP ☐ MetLife ☐ Medi-Cal ☐ None

☐ EyeMed ☐ Private ☐ Medicare ☐ Other _____

Primary holder _____

SSN _____ Date of Birth _____
123 - 45 - 6789 MM / DD / YYYY

Group No. _____

Member ID _____

Employer _____

HEALTH INSURANCE

Name of Provider _____

Primary holder _____

SSN _____ Date of Birth _____
123 - 45 - 6789 MM / DD / YYYY

Group No. _____

Member ID _____

Employer _____

Patient Responsibility Statement

Thank you for choosing Eye Health Optometry for your eye care needs. As your eye care provider, we are committed to providing the best eye care services possible. Please understand that payment of your bill is considered a part of your care. The following statement explains our financial policy, which we ask you to read and sign.

1. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received.
2. All applicable co-pays and non-covered services are due at the time of service.
3. Please be aware that some of the services provided may be non-covered services.
4. We Participate in numerous insurance plans. For some insurance plans, we accept assignment of benefits, but in all cases we require a guarantor, the person who is financially responsible, to be personally liable for all balances not covered by insurance. **While we make every effort to verify and confirm your insurance benefits, it is your responsibility to understand the terms and conditions of you insurance plan.**

Print Name _____ Signature _____ Date _____
MM / DD / YYYY

Notice of Privacy Practices

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. These uses of your protected health information include, but are not limited to: treatment, payment for services, health care operations, public health, legal disclosure, etc. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation. For more on these practices in detail, please visit the U.S. Department of Health and Human Services at www.hhs.gov.

I acknowledge that I have been given the Notice of Privacy Practices from Dr. Jacqueline Tung of Eye Health Optometry.

Print Name _____ Signature _____ Date _____
MM / DD / YYYY

If signing as a personal representative of the patient, describe the relationship to the patient: _____