

“Our Excellence in Eye Care Makes The Difference”
Drs. Davis, Morris, Semel, Davis and Nguyen

Welcome to our office!

Date: _____ Referred by: _____
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Email: _____
Daytime Phone Number: _____ Cell Phone Number: _____
Social Security Number: _____
Date of Birth: _____ Age: _____ Sex: Male Female

Employer Information:

Employer: _____ Title: _____
Work Phone Number: _____

Contact in Case of Emergency:

Name: _____ Relationship: _____
Phone Number: _____

If Patient is a Minor, Please Complete the Following:

Guardian: _____ Relationship: _____
Phone Number: _____

Insurance Information:

Primary Insurance Company: _____
Name of Insured: _____
Relationship to Insured: Self Spouse Dependent
ID#: _____
Is your insurance in a group plan? Yes No
If yes, what is the Employer or Group Name? _____
Vision Insurance: _____

How will you settle your account today?

Cash Check Credit Card Financing

Medical History:

Allergies	Yes	No	Diabetes	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Eye Injury	Yes	No	Kidney Problems	Yes	No
Asthma	Yes	No	Eye Surgery	Yes	No	Nerves	Yes	No
Cataracts	Yes	No	Glaucoma	Yes	No	Skin Disorder	Yes	No
Cancer	Yes	No	Heart Disease	Yes	No	Other:	_____	

Current Medications (Prescription or Over the Counter):

Eye Drops (Prescription or Over the Counter):

Allergies to Medications: _____

Primary Care Physician:

Name: _____

Phone Number: _____

Last Eye Exam: _____

Last Eye Doctor: _____

Family Medical History:

Relationship:

Relationship

Blindness: _____

Heart Disease: _____

Glaucoma: _____

Cancer: _____

Diabetes: _____

Other: _____

Social History:

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

Would you prefer to discuss your social history directly with your doctor? Yes No

Do you use tobacco products? Yes No If yes, how many packs a day? _____

Do you drink alcohol? Yes No If yes, how many drinks a day? _____

Do you use any recreational drugs Yes No If yes, which type? _____

Patient Questionnaire:

What is your primary form of vision correction? Glasses Contacts None

What are the occasions when you do NOT want to wear your glasses?

Sports : _____ Physical Fitness: _____

Hobbies: _____ Business: _____

Other: _____

If you wear contact lenses, what type? Soft Rigid Not sure Does not apply

What is it about your contact lenses that you would like to improve?

(i.e. end of day comfort, dryness, vision, etc): _____

How would you prefer to wear contact lenses? Occasionally Everyday Not Sure Does not apply

Have you worn contact lenses in the past but stopped wearing? Yes No Does not apply

If yes, why did you stop wearing contact lenses?

Cost Uncomfortable Inconvenient Prefer glasses

Other: _____

Do you experience (check those that apply)....

- | | | |
|---|--|--|
| <input type="checkbox"/> Burning | <input type="checkbox"/> Nausea | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Glare or reflections |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Flashes of light |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Floating spots |
| <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Gritty feeling | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Sensitivity to light |

Visual Needs

Do you (check those that apply).....

- Work on the computer for long periods of time?
- Have only one pair of glasses?
- Want information on thinner, lighter lenses?
- Wear bifocals?
- Want information on “no line” bifocals?
- Prefer not to wear glasses at time?
- Spend a lot of time outdoors?
- Ever find a need for prescription sunglasses?
- Have problems with glare or reflections (ex: night driving)
- Require safety glasses?
- Participate in sports? Which ones? _____
- Want more information about LASER VISION CORRECTION?
- Want more information on NON-Surgical Alternatives to LASIK

Acknowledgement of Receipt of Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from The Eye Center of Drs. Davis, Morris, Semel, Davis and Nguyen.

Signature _____

If you are signing as a personal representative of the patient, please describe you relationship to the patient.

Relationship to Patient _____ Print name _____

Financial Responsibility Statement

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any materials or professional services rendered. I certify that all information given is true and correct to the best of my knowledge. I will notify you of any changes in my status.

I request that payment of authorized insurance benefits or medicare be made either to me or on my behalf to THE EYE CENTER for any devices or professional services rendered to me. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Professional fees are due when services are rendered unless prior arrangements are made. A deposit of 50% is required towards the total cost or glasses or contact lenses before an order can be placed. The remaining balance is due at the time of dispensing. When eye glasses are purchased through insurance, the balance is due in full when the order is placed. If contact lenses are being shipped, payment in full is required before order is placed.

Signature _____

If you are signing as a personal representative of the patient, please describe you relationship to the patient.

Relationship to Patient _____ Print name _____

Thank you for your cooperation.