

Welcome to Westside Optometry

PERSONAL INFORMATION

Name _____ Nickname _____ Date _____

[] Mr. [] Mrs. [] Ms. [] Dr. [] Miss. [] Rev. If child, parent's name? _____

Preferred Method of Contact? Cell Home Work Email

Street _____ City _____

Zip _____ Home Phone _____ Work Phone _____

Birthdate _____ Social Security Number _____

Cell# _____ Email _____

Would you like to receive our newsletter and practice announcements? Y N

Occupation _____ Employer _____

Hobbies/Sports _____

Primary Language _____

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, Decline to Specify

Ethnicity: Not Hispanic or Latino, Hispanic or Latino, Decline to Specify

How did you hear about us? [] Insurance [] Yellow Pages [] Internet [] Newsletter [] Other? [] Family/Friend Who? _____

OCULAR HISTORY

Concerns or problems with your eyes _____

Are you interested in glasses today? _____ Contact Lenses? _____ LASIK? _____

Last Eye Exam _____ From Dr. _____ Results _____

Last Physical Exam _____ From Dr. _____ Results _____

Do you wear Contact Lenses now? _____ (if "yes" mark all that apply)

[] soft [] gas permeable [] monovision [] bifocal [] extended wear [] other? _____

Explain any eye injuries and/or surgeries _____

FAMILY HISTORY

Family history unknown, I'm adopted []

Please note any family history (parents, grandparents, siblings, children, living or deceased)

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Glaucoma	[]	[]	[]	_____
Cataracts	[]	[]	[]	_____
Macular Degeneration	[]	[]	[]	_____
Eye Injury	[]	[]	[]	_____
Retinal Detachment/Disease	[]	[]	[]	_____
Other Eye Disease	[]	[]	[]	_____
Blindness	[]	[]	[]	_____
Strabismus	[]	[]	[]	_____
Diabetes	[]	[]	[]	_____
Cancer	[]	[]	[]	_____
Heart Disease	[]	[]	[]	_____
Kidney Disease	[]	[]	[]	_____
Thyroid Disease	[]	[]	[]	_____

Other _____

Please turn this form over and complete the other side

FINANCIAL POLICY

We provide the highest quality eye and vision care for our patients. In return for our uncompromising standards and service, we ask that our patients keep their accounts current. Please read, initial and sign the following FINANCIAL POLICY. If you have any questions please feel free to ask us.

Patients are expected to pay in full at the time services are rendered, and pay at least 50% towards material fees when ordered. The balance is due upon delivery of the product(s). We accept cash, checks, Visa and MasterCard. After 30 days, account balances are considered delinquent and subject to a billing charge. There is a \$10 fee for returned checks. _____

Initial

INSURANCE INFORMATION

As a courtesy to our patients we accept assignment for Vision Service Plan, Medi-Cal, Medicare, Vision Care Plan and Safeguard. Copayments, deductibles and charges not covered by these plans are the patient's responsibility.

What is your vision plan? []None []VSP []Medicare []Medi-Cal []VCP []Safeguard []Other _____

Subscriber's Name _____ Subscriber's Birthdate _____

Subscriber's Social Security Number _____

What is your medical insurance? _____ Primary Care Physician _____

If you notify us after services are rendered and materials ordered that you have vision insurance, we will supply you with a coded receipt that you can submit to receive reimbursement directly from your plan. However, be aware that your insurance company may only send you a partial reimbursement of the fees you paid.

I have read, understand and agree to the above financial policy for payment of professional services and product fees.

Responsible person's signature or parent if minor

Date

SIGNATURE ON FILE (PLEASE COMPLETE IF YOU HAVE VISION INSURANCE)

I certify that the information given to me in applying for payment under title XVII of the Social Security Act is correct.

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance companies.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I permit a copy of this authorization to be used in place of the original.

Beneficiary or Guardian's Signature

Date

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by HIPAA, we have prepared a **NOTICE OF PRIVACY PRACTICES POLICY**. This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request and on our website. _____

Initial

We appreciate the opportunity to serve you, your family and your friends. Our commitment is to provide you with the highest quality service and products. Thank you for your attention in providing us the above information.

Name _____ Date _____

SOCIAL HISTORY This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. [] Yes, I would prefer to discuss my Social History information directly with the doctor.

Do you drive? Yes [] No [] If yes, do you have visual difficulties? Yes [] No [] If yes, please describe: _____

Do you use tobacco products? Yes [] No [] If yes, type, amount and how long? _____

Do you drink alcohol? Yes [] No [] If yes, type, amount and how often? _____

Do you use illegal drugs? Yes [] No [] If yes, type, amount and how often? _____

HEALTH HISTORY

Do you have any allergies to medications? _____ To what? _____

List any medications you are presently taking (including oral contraceptives, aspirin, over-the-counter drugs and natural remedies) _____

List all major injuries and surgeries and/or hospitalizations you have had _____

REVIEW OF SYSTEM

Do you currently have any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
Constitutional				Ear, Nose, Mouth and Throat			
Fever, Weight Loss/Gain	[]	[]	[]	Allergies/Hayfever	[]	[]	[]
Integumentary (Skin)	[]	[]	[]	Sinus Congestion	[]	[]	[]
Neurological				Runny Nose	[]	[]	[]
Headache	[]	[]	[]	Post-Nasal Drip	[]	[]	[]
Migraine	[]	[]	[]	Chronic Cough	[]	[]	[]
Seizures	[]	[]	[]	Dry Throat/Mouth	[]	[]	[]
Eyes				Respiratory			
Loss of Vision	[]	[]	[]	Asthma	[]	[]	[]
Blurred Vision	[]	[]	[]	Chronic Bronchitis	[]	[]	[]
Distorted Vision/Haloes	[]	[]	[]	Emphysema	[]	[]	[]
Loss of Side Vision	[]	[]	[]	Vascular/Cardiovascular			
Double Vision	[]	[]	[]	Diabetes	[]	[]	[]
Dryness	[]	[]	[]	Heart Pain	[]	[]	[]
Mucous Discharge	[]	[]	[]	High Blood Pressure	[]	[]	[]
Redness	[]	[]	[]	Vascular Disease	[]	[]	[]
Sandy or Gritty Feeling	[]	[]	[]	Gastrointestinal			
Itching	[]	[]	[]	Diarrhea	[]	[]	[]
Burning	[]	[]	[]	Constipation	[]	[]	[]
Foreign Body Sensation	[]	[]	[]	Genitourinary			
Excess Tearing/Watering	[]	[]	[]	Genitals/Kidney/Bladder	[]	[]	[]
Glare/Light Sensitivity	[]	[]	[]	Bones/Joints/Muscles			
Eye Pain or Soreness	[]	[]	[]	Rheumatoid Arthritis	[]	[]	[]
Chronic Eye Infection	[]	[]	[]	Muscle Pain	[]	[]	[]
Sties or Chalazion	[]	[]	[]	Joint Pain	[]	[]	[]
Flashes/Floaters in Vision	[]	[]	[]	Lymphatic/Hematologic			
Tired Eyes	[]	[]	[]	Anemia	[]	[]	[]
Endocrine				Bleeding Problems	[]	[]	[]
Thyroid/Other Glands	[]	[]	[]	Allergic/Immunologic	[]	[]	[]
				Psychiatric	[]	[]	[]

If you answered YES to any of the above or have a condition not listed, please explain below:

Doctor's Signature

Date