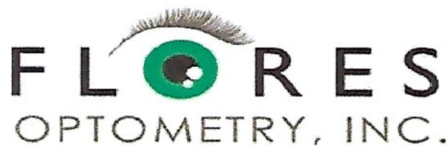

Patient Information

Date: ____________________

Check One: ☐Mr . ☐ Ms. ☐ Miss ☐ Mrs. ☐ Dr. ☐ Minor (Parent's name if minor) :_________________________________

Name: ____ Date of Birth: __________________________

Address: ____ SSN: _________________________________

City/Zip: ____ Cell Phone: __________________ Ok to Text: Y/N

E-mail: ____ Home Phone: ____________________________

Employer: ____________________________ Occupation: _____________________

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

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

Referred by: ____ ☐ Insurance Co. ☐ Yelp ☐ Doctor ☐ Friend ☐ Family

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 #: ____

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 **authorize** Flores Optometry Inc. to contact me by telephone or other media devices for communications needed to monitor my progress to recommended care.

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

______ 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.

Signature: ____ Relationship to Patient (if minor): __________________________

Revised 03/25/2020 VE

GENERAL HEALTH INFORMATION SHEET

Reason for visit today: ____

Last eye exam date: ____________________ Name of previous Optometrist: ______________________________

I wear glasses: yes / no I wear contact lenses: yes / no Brand: ______________________________

I have had laser corrective surgery: yes / no Surgery date: ____________________

Any known eye conditions: i.e. cataracts, glaucoma, macular degeneration, retinal detachment, etc. ________________

____

Please list any allergies: ____

Please list any medications: ____

____

Check √ if any of these apply: Please list condition/disorders when appropriate

___Sudden blurriness	___Headaches (migraines, ocular headaches)	___Hypertension
___Double vision	___Pregnant or nursing	___High Cholesterol
___Flashes/ Floaters in vision	___Diabetes: Last A1C or Blood Sugar Level______	___Asthma
___Dry Eye/ Burning sensation	___Thyroid Disorder: ____________________	___Arthritis
___Itchy Eyes	___Heart Condition: ____________________	___Multiple Sclerosis
___Redness	___Kidney/Liver Condition: ________________	
___Sandy or gritty feeling	___Stomach/Digestive: ________________	
___Watering eyes	___Skin Condition: ____________________	
___Glare/ Light sensitivity	___Psychological/Neurological: ____________	
___Eye pain	___Blood Disorder: ____________________	
___Eye Fatigue/Tired eyes	___Ear/Nose/Mouth/Throat: ______________	
___Lazy eye / eye turn	___Cancer (Type): ____________________	

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

Any other health conditions not listed above: ____

Check √ if any of these apply: Tobacco:___light___mod___heavy Alcohol: ___light___mod___heavy Druguse:___light___mod___heavy

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

	Relationship			Relationship	
___Glaucoma	____________________	Maternal/Paternal	___High Blood Pressure	________________	Maternal/Paternal
___Cataracts	____________________	Maternal/Paternal	___Heart Disease	____________________	Maternal/Paternal
___Macular Degeneration	____________	Maternal/Paternal	___Diabetes	____________________	Maternal/Paternal
___Retinal Detachment	______________	Maternal/Paternal	___Thyroid Condition	________________	Maternal/Paternal
___Blindness	____________________	Maternal/Paternal	___Other	______________________________	

Signature: ______________________________ Relationship to Patient (if minor): ______________________________

Revised 03/25/2020 VE