



Welcome to Our Office

So that we can help you best, please fill out both pages legibly and completely.

Full Name _____ Name you go by (if different) _____ Home address _____ City _____ State _____ Zip _____ Home phone ____ (____) _____ Cell phone ____ (____) _____ E-mail address _____ (for exam information, statements, product info, notifications, etc)	Today's date _____ Date of birth _____ Sex: M F Social security number _____ Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Employer (or School) _____ Occupation (or Grade) _____ Who is responsible for paying your account balance? <input type="checkbox"/> Yourself <input type="checkbox"/> Other Name & Relationship: _____
Medical Insurance _____ Name of Primary Care Physician _____ Is it an <input type="checkbox"/> HMO (Health Maintenance Organization, e.g. Kaiser, Sharp, Scripps) <input type="checkbox"/> PPO (Preferred Provider Organization, e.g. Blue Cross)	
Are you a member of an eye care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please circle your plan below: Vision Service Plan (VSP) Medical Eye Services (MES) EyeMed / ECPA Superior Vision Other _____	
How did you first hear about us? <input type="checkbox"/> Eye care plan directory <input type="checkbox"/> Newspaper or TV <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Internet <input type="checkbox"/> Family, friend, or co-worker <input type="checkbox"/> Doctor referral If another person recommended us, who : _____	
Reason(s) for your visit today? <input type="checkbox"/> New glasses <input type="checkbox"/> Routine check-up <input type="checkbox"/> Contact lens evaluation <input type="checkbox"/> Ocular health evaluation <input type="checkbox"/> Vision Therapy <input type="checkbox"/> School referral <input type="checkbox"/> Failed DMV eye test <input type="checkbox"/> Laser Vision Correction evaluation <input type="checkbox"/> iZON™ high definition glasses <input type="checkbox"/> Other _____	
When was your last comprehensive eye examination? <input type="checkbox"/> Never <input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4 years <input type="checkbox"/> 5+ years	
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do you wear them <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seldom	
For what purpose were they prescribed? <input type="checkbox"/> General use <input type="checkbox"/> Distance Only <input type="checkbox"/> Near Only <input type="checkbox"/> Computer Use <input type="checkbox"/> Occupational <input type="checkbox"/> Safety <input type="checkbox"/> Sport	
Describe your computer use: <input type="checkbox"/> Extensive (5+ hrs/day) <input type="checkbox"/> Moderate (1-4 hrs/day) <input type="checkbox"/> Low (Less than 1 hr/day) <input type="checkbox"/> Seldom <input type="checkbox"/> Never	
Chief complaint(s): <input type="checkbox"/> None <input type="checkbox"/> Distance Blur <input type="checkbox"/> Near Blur <input type="checkbox"/> Intermediate Blur <input type="checkbox"/> Computer blur & eye fatigue <input type="checkbox"/> Trouble reading <input type="checkbox"/> Headaches <input type="checkbox"/> Eyestrain <input type="checkbox"/> Eyes burn <input type="checkbox"/> Eyes water <input type="checkbox"/> Pressure around eyes <input type="checkbox"/> Eyes feel sandy/gritty <input type="checkbox"/> Eye pain <input type="checkbox"/> Eyes red <input type="checkbox"/> Floaters / Flashes <input type="checkbox"/> Double vision <input type="checkbox"/> Decreased side vision <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Eyes itch <input type="checkbox"/> Other (describe) _____	
Eye surgeries: <input type="checkbox"/> None <input type="checkbox"/> LASIK <input type="checkbox"/> PRK <input type="checkbox"/> RK <input type="checkbox"/> Intacs™ <input type="checkbox"/> Cataract <input type="checkbox"/> Retinal <input type="checkbox"/> Glaucoma <input type="checkbox"/> Eyelid <input type="checkbox"/> Other _____	
Have you had a serious eye injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe _____	
Any other eye problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe _____	
Which statement applies to you? <input type="checkbox"/> I've never worn contacts (skip rest of this section) <input type="checkbox"/> I wear contacts daily <input type="checkbox"/> I wear contacts occasionally <input type="checkbox"/> I used to wear contacts	
If you wear contacts, do you sleep with them regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many nights in a row will you wear them without removal? _____	
Are your contacts <input type="checkbox"/> Soft <input type="checkbox"/> Rigid <input type="checkbox"/> Disposable <input type="checkbox"/> Non-disposable <input type="checkbox"/> Monovision <input type="checkbox"/> Bifocal / Multifocal <input type="checkbox"/> For astigmatism <input type="checkbox"/> Other _____	
If soft disposable, which brand and lens power are you wearing (if known) _____	
How old is the pair you are currently wearing? _____ How frequently do you replace a pair? _____	

Please complete the second page . . .

Welcome to Our Office, Page 2

Family Medical History			
Blindness or Visual Disability	Y	N	Unsure
Cataracts	Y	N	Unsure
Diabetes	Y	N	Unsure
Glaucoma	Y	N	Unsure
High Blood Pressure	Y	N	Unsure
Macular Degeneration	Y	N	Unsure
Other disease (please specify) _____			

Personal Medical History

Since many general medical conditions can affect the eye, we need to know of any medicines you take and any medical conditions you have

Do you take any prescription or non-prescription medicines regularly? Y N (If yes, please list all below or provide as attachment)

Medication allergies: None known Penicillin Sulfa drugs Codeine Other _____

Do you have any conditions of the following medical systems? (Please circle) **If yes, please explain**

Ear / nose / throat (e.g. soreness, hearing loss)	Y	N	_____
General constitution (e.g. fever, weight gain/loss, malaise)	Y	N	_____
Blood (e.g. anemia, bleeding disorders)	Y	N	_____
Genitourinary (e.g. kidney failure, prostate/ovarian cancer)	Y	N	_____
Muscle / joints (e.g. weakness, arthritis)	Y	N	_____
Endocrine (e.g. diabetes, hypo- or hyper-thyroid)	Y	N	_____
Skin (e.g. rash, dryness)	Y	N	_____
Cardiovascular (e.g. high blood pressure, stroke, heart)	Y	N	_____
Neurologic (e.g. tingling, numbness, headaches)	Y	N	_____
Respiratory (e.g. shortness of breath, asthma)	Y	N	_____
Psychiatric (e.g. depression, memory loss)	Y	N	_____
Gastrointestinal (e.g. stomach pain, diarrhea, constipation)	Y	N	_____
Allergic / Immunologic (e.g. hayfever, HIV)	Y	N	_____

So that we can get to know you better, what hobbies, sports, or other activities do you enjoy?

PRIVACY PRACTICES ACKNOWLEDGEMENT AND 3RD PARTY PAYMENT AUTHORIZATION

I acknowledge that I have received a copy of Carmel Mountain Vision Care's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, www.CarmelMountainVisionCare.com. Additionally, I authorize the payment of any eye care benefits or medical insurance to my Doctor of Optometry. I understand that I may have co-payments, deductibles, and coverage costs, and ultimately I am responsible for all fees incurred.

Patient name _____ Signature of patient (or parent/guardian for minors) _____

Thank you!