

# PATIENT INFORMATION

M / F Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Birth Date \_\_\_\_\_

If patient is under 18 years old: Mother \_\_\_\_\_ Father \_\_\_\_\_  
In custody of:  both parents  Mother  Father  Guardian / Relation \_\_\_\_\_

Address \_\_\_\_\_

Cell Phone \_\_\_\_\_ Secondary Tel: home / work / cell \_\_\_\_\_

Email \_\_\_\_\_ Occupation/Grade Level & Employer/School \_\_\_\_\_

Referred By:  walk by  insurance listing  family  friend  family doctor  other \_\_\_\_\_

Emergency contact: Name \_\_\_\_\_ relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Previous Patient? Y / N ; Date of Last Eye Exam \_\_\_\_\_ From Dr. \_\_\_\_\_

History of Glasses Wear:  Never  Age of present glasses \_\_\_\_\_

History of Contacts Wear:  Never  Last worn contacts \_\_\_\_\_

Reason for Today's Visit:  Eye problem(s): such as red eyes, itchy eyes, watery eyes, eye pain, seeing spots etc.  
 Vision Problem(s): Need/want new/update glasses and/or contact lenses  
 No problem; Eye wellness check  
 Other \_\_\_\_\_

Are you planning to get new glasses today?  yes  no  undecided New contacts today?  yes  no  undecided

Do you or any of family members (Grandparents, parents, brothers or sisters) have any of these conditions?

	Self	Family	None		Self	Family	None		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you see double?	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes Been dilated	<input type="checkbox"/>	<input type="checkbox"/> year? _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Primary Care Dr. _____		

Note for positive findings \_\_\_\_\_

List of current eye drops (prescription or over the counter):  None  List \_\_\_\_\_

List of current all other medications (prescription or over the counter):  None  List \_\_\_\_\_

Known food or medication allergies:  None  List: \_\_\_\_\_

List any person or entity (spouse, parents, children, or doctor office) that you approve to receive your protected health information and financial information without any further authorization. (let us know if you want more than 2 people)

1) \_\_\_\_\_ Name \_\_\_\_\_ Relation \_\_\_\_\_ 2) \_\_\_\_\_ Name \_\_\_\_\_ Relation \_\_\_\_\_

By signing below, I acknowledge that

- 1) I voluntarily consent to any and all eye care treatment and diagnostic procedures by Monrovia Optometry and its associated doctors and other personnel.
- 2) I have read, understand, and/or received a copy of the HIPAA disclosure (Notice of Privacy Practice) and Office Policies.
- 3) I understand that eligibility and benefit provided by the insurance / vision plan are not a guarantee of payment. I authorize MONROVIA OPTOMETRY to release any information to process all insurance claims for services rendered. I also authorized payment of benefits directly to this office. I understand that I am responsible for any charge not paid by my insurance / vision plan as well as any deductible and / or co-pays.

Patient / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only:** Health Insurance ( PPO / HMO ):  Anthem  Blue Cross  Blue Shield  Health Net  kaiser  United Health Care  Other  
Vision Plan:  Self Pay  VSP: sig - choice - value - essen  EyeMed  MCal: reg - VSP - March - Envolve  Davis  Spectera  other \_\_\_\_\_  
Insured Name \_\_\_\_\_ Relationship to patient:  self  spouse  parent [Insured  
DOB \_\_\_\_\_ Last 4 SS# \_\_\_\_\_ ID # \_\_\_\_\_