Date:_______________ **NEW PATIENT INFORMATION** Check-in by:_______________

Preferred Language: ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Vietnamese ☐ others _______________

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	☐	☐	☐	Retinal Disease	☐	☐	☐	Do you see double?	☐	☐
High Blood Pressure	☐	☐	☐	Glaucoma	☐	☐	☐	Frequent headaches?	☐	☐
High Cholesterol	☐	☐	☐	Cataracts	☐	☐	☐	Are you pregnant?	☐	☐
Heart Disease	☐	☐	☐	Eye Surgery	☐	☐	☐	Are you breastfeeding?	☐	☐
Asthma	☐	☐	☐	Eye Injury	☐	☐	☐	Eyes Been dilated	☐	☐
Other	☐	☐	☐	Other	☐	☐	☐	Primary Care Dr. _______________		

Additional Comments: ____

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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 ______________________

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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 __________________________

Print Name of the Signer for Minor________________________________ Relation ________________________

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 ☐ other_____________

DOB____________________ Last 4 SS#_______________ ID # ______________________________________