

Oakland Vision

Date ___/___/___

Last Name _____ First Name _____ MI _____ DOB: ___/___/___

M or F SSN: ___/___/___ Marital Status: Married / Single / Divorced / Widowed

Sports/Hobbies: _____ Spouse/Guardian: _____

Race: American Indian/ Alaska Native, Black/ African American, Native Hawaiian/ Pacific Islander, White, Other Race, Decline
Ethnicity: Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline

Height: _____ Weight _____ Preferred Language: English / Spanish / Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph:() _____ - _____ Work Ph:() _____ - _____ Ext: _____ Cell Ph:() _____ - _____

Dependant Mother's Name: _____ SSN: ___/___/___

Address if different: _____ DOB: _____

Dependant Father's Name: _____ SSN: ___/___/___

Address if different: _____ DOB: _____

Employer/School: _____ Occupation/ School Grade: _____

E-mail Address: _____ Preferred Contact: Cell / Home / Text / E-mail / U.S. Mail

Emergency Contact: _____ Relation: _____ Phone #:() _____ - _____

Would you like to receive text or email notifications? Yes / No

How did you hear about our office? _____ Are you currently pregnant or nursing? Yes / No / N/A

Date of Last Medical Exam: ___/___/___ Primary Physician/Clinic: _____

Address: _____ Phone() _____ - _____

Date of Last Eye Exam: ___/___/___ Clinic/Eye Doctor's Name: _____

Do you wear glasses? Yes / No / All the time / Sometimes / Work only / Reading only / Driving only

How old are your present glasses? _____ years Do you wear prescription Sun Wear? Yes/No

Are you interested in contacts? Yes / No Do you wear contacts? Yes / No Type: _____

Solution Used: _____ Wearing schedule: **Daily Overnight**

Replacement Schedule: **Daily / 2 week / Monthly / Yearly** Are you interested in LASIK? Yes / No

What are your visual symptoms today: Please circle any that apply:

Please indicate Right, Left, or Both, along with severity 1(Low) 2(Moderate) 3(High)

- | | | | | | |
|--|-------|--|-------|---|-------|
| <input type="checkbox"/> Blurred Vision/Distance | R L B | <input type="checkbox"/> Dry Eyes | R L B | <input type="checkbox"/> Headaches | R L B |
| <input type="checkbox"/> Blurred Vision/Near | R L B | <input type="checkbox"/> Red Eyes | R L B | <input type="checkbox"/> Migraine Headaches | R L B |
| <input type="checkbox"/> Double Vision | R L B | <input type="checkbox"/> Watery Eyes | R L B | <input type="checkbox"/> Loss of Vision | R L B |
| <input type="checkbox"/> Eye Strain | R L B | <input type="checkbox"/> Wandering Eye | R L B | <input type="checkbox"/> Crossed Eyes | R L B |
| <input type="checkbox"/> Eye Infections | R L B | <input type="checkbox"/> Mucus Discharge | R L B | <input type="checkbox"/> Light Sensitive | R L B |
| <input type="checkbox"/> Eye Pain/Soreness | R L B | <input type="checkbox"/> Floaters or Spots | R L B | <input type="checkbox"/> Gritty Feeling | R L B |
| <input type="checkbox"/> Tired Eyes | R L B | <input type="checkbox"/> See Flashes | R L B | <input type="checkbox"/> Poor Color Vision | R L B |
| <input type="checkbox"/> Burning Eyes | R L B | <input type="checkbox"/> See Halos | R L B | <input type="checkbox"/> Droopy Lid | R L B |
| <input type="checkbox"/> Itchy Eyes | R L B | <input type="checkbox"/> Poor Night Vision | R L B | | |

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU, AND LIST ANY MEDICATION FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: <input type="checkbox"/> None <input type="checkbox"/> Hypertension (High Blood Pressure) <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Other:	Endocrine: <input type="checkbox"/> None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	Respiratory: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:
Constitutional: <input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	Ocular: <input type="checkbox"/> None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other:	Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
Neurological: <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other:	Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	Immunologic: <input type="checkbox"/> None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
Hematological: <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	Gastrointestinal: <input type="checkbox"/> None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	Ear/Nose/Throat: <input type="checkbox"/> None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
Dermatologic: <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	Drug Allergies: (please list) <input type="checkbox"/> None Environmental Allergies:	Alcohol Use: Yes / No Amount: Tobacco Use: Yes / No Amount:

Have you had any operations? Yes / No What? _____

Have you ever had an eye injury? Yes / No : Right / Left What? _____

Have you ever had eye surgeries? Yes / No Why? _____

Have you used eye medications? Yes / No Why? _____

Do you get headaches? Yes / No How often? _____

Have you ever been diagnosed with?

Cataracts: Yes / No When were you diagnosed? _____

Glaucoma: Yes / No When were you diagnosed? _____

Macular Degeneration: Yes / No When were you diagnosed? _____

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE/ CONDITION	RELATION	DISEASE/ CONDITION	RELATION
Retinal Detachment:	Y / N	Blindness:	Y / N
High Blood Pressure:	Y / N	Cataracts:	Y / N
Diabetes:	Y / N	Glaucoma:	Y / N
Cancer:	Y / N	Crossed Eyes:	Y / N
Heart Disease:	Y / N	Macular Degeneration:	Y / N
Thyroid Disease:	Y / N	Lupus	Y / N

Please list any medications and/or drugs that you are taking (including herbal): See Attached List: _____

1	For:	6	For:
2	For:	7	For:
3	For:	8	For:
4	For:	9	For:
5	For:	10	For:

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Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: _____ DOB _____

Name of Insured: _____ Relation: _____ DOB _____

Address of Insured (if different): _____

Name of Insurance Carrier: _____

ID#: _____ Policy #: _____

Insurance Card Copied: _____ Yes _____ No _____ No Card

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: _____

Signature of patient or parent if minor

Date

HIPAA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: _____ Date: _____