Oakland Vision

Date____/____/______

Last Name___________________________ First Name____________________ MI_________ Nickname:___________

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:( )______-________

Mother/Guardian's Name: (if minor)____ SSN:_______/_____/________

Address if different:____ DOB:_____________________

Father/Guardian's Name: (if minor)____ 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

Primary Care Physician:____Date of Last Medical Exam:_____/___/_____

Primary Physician Address:____

Pharmacy:_____________________________Pharmacy Address____

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

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 glasses? Yes / No

Do you wear contacts? Yes / No Type:______________________________ All Day Comfort? Yes / No

Are you interested in contacts? Yes / No 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)

[ ]Blurred Vision/Distance	R L B	[ ]Dry Eyes	R L B	[ ]Headaches	R L B
[ ]Blurred Vision/Near	R L B	[ ]Red Eyes	R L B	[ ]Migraine Headaches	R L B
[ ]Double Vision	R L B	[ ]Watery Eyes	R L B	[ ]Loss of Vision	R L B
[ ]Eye Strain	R L B	[ ]Wandering Eye	R L B	[ ]Crossed Eyes	R L B
[ ]Eye Infections	R L B	[ ]Mucus Discharge	R L B	[ ]Light Sensitive	R L B
[ ]Eye Pain/Soreness	R L B	[ ]Floaters or Spots	R L B	[ ]Gritty Feeling	R L B
[ ]Tired Eyes	R L B	[ ]See Flashes	R L B	[ ]Poor Color Vision	R L B
[ ]Burning Eyes	R L B	[ ]See Halos	R L B	[ ]Droopy Lid	R L B
[ ]Itchy Eyes	R L B	[ ]Poor Night Vision	R L B	[ ]Pain 0-10 _______	R L B

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

Cardiovascular: __None __Hypertension (High Blood Pressure) __High Cholesterol __Stroke __Heart Disease __Other:	**Endocrine:** __None __Thyroid Problem __Hormonal Dysfunction __Non-Insulin Dependent Diabetes HA1C__ __Insulin Dependent Diabetes HA1C__ __Other:	**Respiratory:** __None __Asthma __Bronchitis __Emphysema __COPD __Other:
Constitutional: __None __Cancer Type:__________________ __Trauma/Large Volume Blood Loss __Developmental Disability __Other:	**Ocular:** __None __Glaucoma __Macular Degeneration __Detached Retina __Diabetic Retinopathy __Other:	**Psychiatric:** __None __ADHD __Depression __Schizophrenia __Other:
Neurological: __None __Multiple Sclerosis __Epilepsy __Cerebral Palsy __Tumor __Other:	**Musculoskeletal:** __None __Osteoarthritis __Fibromyalgia __Muscular Dystrophy __Ankylosing Spondylitis __Other:	**Immunologic:** __None __AIDS or HIV __Rheumatoid Arthritis __Lupus __Neurofibromatosis __Crohns
Dermatologic: __None __Eczema __Rosacea __Psoriasis __Other:	**Reproductive:** (please list) __None __Pregnant __Nursing	**Alcohol Use:** **Yes / No** Amount: **Tobacco Use: Current/Former/Never** Amount:

Past Medical History:

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?_____________________________

Diabetic Retinopathy: Yes / No When were you diagnosed?_____________________________

I AUTHORIZE OAKLAND VISION to obtain my prescription medications through my pharmacy. Yes / No, Initial____________

Medications:

1		For:
2		For:
3		For:
4		For:
5		For:

Allergies:	Reaction:

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

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

OAKLAND VISION

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:** _______________

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