

PATIENT'S INFORMATION (Please Print)

Date _____

Name _____ Birthdate ____/____/____ Age _____ Sex: M F

Home Address _____

City _____ State _____ Zip _____ Home Phone() _____

Employed By _____ Occupation _____ Work Phone () _____

Insurance _____ Social Security # _____ E-mail _____

What is the reason for today's visit? _____

Who Referred You To This Office? _____

SUBSCRIBER'S INFORMATION (If different from above)

Name _____ Birthdate ____/____/____ Sex: M F

Address _____ City _____ State _____ Zip _____ Home Phone() _____

Employed By _____ Work Phone() _____ Social Security _____

PATIENT'S EYE/MEDICAL HISTORY

1. When was your last eye exam? _____ What Doctor? _____
2. Have your eyes ever been dilated? N Y When was your last dilation? _____
3. Do you currently wear glasses? N Y How old are they? _____
4. Do you currently wear contact lenses? N Y What brand? _____ Solution? _____
5. Have you ever had an eye infection? N Y Please describe _____
6. Have you ever had an eye injury? N Y Please describe _____
7. Have you ever had any eye surgeries? N Y Please describe _____
8. Do you or any blood relatives have the following conditions?

- High Blood Pressure Self Other _____
- Diabetes Self Other _____
- Heart Disease Self Other _____
- Macular Degeneration Self Other _____
- Cataracts Self Other _____
- Glaucoma Self Other _____
- Retinal Disease Self Other _____

- Seeing flashes Self Other _____
- Loss of vision Self Other _____
- Floater Self Other _____
- Lazy eye Self Other _____
- Crossed Eye Self Other _____
- Double Vision Self Other _____
- Other Self Other _____

9. Please list all medications you are currently taking: _____

10. Are you allergic to any medications? N Y What kind? _____

Payment Authorization -- I authorize payment of all vision benefits for services and/or materials rendered *directly* to the doctor or provider as indicated. I understand that I am responsible for any payment not covered by the insurance plan and that services rendered and materials dispensed are not refundable. I also hereby authorize the release of information regarding my medical and vision history for the purpose of validating and determining benefits payable in connection with the insurance claim.

Patient's Signature (or Guardian)

Notice of Privacy Practices— I have had the opportunity to review Porter Ranch Optometry's Notice of Privacy Practices. I **do / do not** (please circle one) choose to have a copy of the Notice of Privacy Practices.

Patients Signature (or Guardian)