Colton Optometric Group - Patient History Questionnaire

Last Name _____ First Name _____ M / F Today's Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Birthdate _____ Social Security # XXX-XX-_____ Date of Last Exam _____
Emergency Contact Person/Relationship _____ / _____ Phone _____

Medical Information

How is your general health? _____ Do you have any problems with or take any medications for the following systems?
Please Circle:

Gastrointestinal Nervous System Endocrine (glands) Ear/Nose/Throat Urinary Skin Mental
Blood/Lymph Cardiovascular Muscles/Bones Allergic/Immunologic Respiratory Headache
Diabetes High Blood Pressure

Please Explain: _____
Other Health Problems: _____
Current Medication(s): _____
Medication Allergies: _____ List Any Operations: _____
Name of Family Doctor or Primary Care Physician _____

Family History

Does any member of your family have any of the following? Please circle & list relationship
High Blood Pressure _____ Diabetes _____ Macular Degeneration _____
Cataracts _____ Glaucoma _____ Retinal Detachment _____

Personal Eye Information

Do you have or are you being treated for any of the following eye problems? Please circle
Dry Eye Itchy Eyes Blurred Vision Double Vision Distorted Vision Redness Irritation Glare Excessive Tearing Floaters
Loss of Side Vision Flashing Lights Eye Fatigue Pain Glaucoma Cataracts Macular Degeneration Diabetic Retinopathy
If yes, please explain and list any medications: _____
Circle if you currently wear either: Glasses or Contact Lenses

During our pre-testing for a complete exam we may be taking a retinal photograph of each eye if you are 21 years of age or older to aid in your eye health evaluation. This is a photograph and not an x-ray. We strongly advise that you take this test to document your current eye health or any eye health problems. Please let us know if you do not want this test performed prior to your examination with Dr. Law.

*** Also, in order to perform a more detailed examination of your eyes it may be necessary to dilate your pupils using drops. If you are dilated you may experience some blurred vision at far and near distances and some increased sensitivity to light for up to 4 hours. Please note below if you approve having this test performed if it is needed during your examination:

Yes No

Please sign after you have completed the history form _____ _____
Patient/Guardian Signature Date

Colton Optometric Group Patient Consent Form

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) you have certain rights to privacy regarding your protected health information. In order to properly provide eye care services for you the Colton Optometric Group may need to use or disclose some personal health information with other health care providers, various vision plans or insurance groups and various public entities. Examples of personal health information are your name, your address, your telephone number, your employer and dates of service in our office. We will only use or disclose this information when absolutely necessary in order to:

(1) give vision information to another health care provider, the Department of Motor Vehicles, school or other entity upon your direction,
(2) bill your Vision or Medical plan for services rendered at our office,
(3) provide information for quality assurance reviews and provider certifications or
(4) to contact you regarding care at our office as well as future appointments.

We are required to protect this private information for you. You have the right to revoke this authorization at any time. Any other use or disclosure of personal health information will only be made if you personally sign a separate authorization. If you feel that your privacy rights have been violated at any time you may file a complaint with either our office and/or the Department of Health and Human Services. Our privacy officer here at the **Colton Optometric Group** is Tina Rico and she may be contacted directly at our office phone #: 909-825-9044 should you have any questions. By signing this authorization you are confirming that you understand how our office will use or disclose personal health information as noted above and that you consent to the eye examination procedures we will use to provide your vision care at our office.

_____ _____
Patient Signature or Parent/ Guardian signature Relationship if signing for a Minor patient or as the patient's representative