Today's Date_____ Patient Name:_____
First Last MI

Patient's Social Security #:_____ Patient's Birthdate:_____/_____/_____
Month Day Year

Patient's Address:_____
Street City State Zip

Phone # _____ _____ _____
Home Work Cell

Sex: □ M □ F □ _____ □ Married □ Widowed □ Single □ Separated □ Divorced □ Partnered

Occupation:_____ Employer:_____

Spouse's Name:_____ Spouse's occupation:_____

Name of Vision Insurance Plan:_____ □ None

Subscriber's:_____ _____ _____
Name Social Security # Date of Birth

Who is your primary care physician:_____ □ none
What medical insurance do you use to see this physician:_____ □ none
What is your preferred pharmacy:_____ □ Ojai □ Ventura □ _____

Name of Medication	Dose	Reason for taking

Please give our receptionist any major medical or vision insurance cards for us to photocopy.
I agree to pay any fees that are denied or not covered by my insurance:
I certify that I, and/or my dependent (s) have insurance coverage that I presented and assign directly to Drs. Brockman & Tsao all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the disclosure of my health care information as needed to process these claims.

X _____

Allergies: Please list any medications that you are allergic to: □ none

_____ □ anaphylactic reaction (you stop breathing) □ other_____

_____ □ anaphylactic reaction (you stop breathing) □ other_____

please turn and complete back page →

Please list any surgeries you have had (including chemotherapy, radiation): □ none

_____

_____

_____

Eye surgeries :_____ □ none

Name of eye surgeon/ dates if known:_____

Check if you or a family member have:

	self	which relative (if any)
high blood pressure	□	_____
diabetes	□	_____
high cholesterol	□	_____
heart disease	□	_____
cataracts	□	_____
glaucoma	□	_____
macular degeneration	□	_____

other: _____

_____

Check if you have:

□ food or environmental allergies
□ indigestion
□ headache
□ migraine
□ arthritis
□ sinus congestion
□ thyroid problems
□ recent weight loss or gain
□ shortness of breath
□ anxiety or depression

□ Hepititis □A □B □C
□ HIV / Aids

Any additional information that you would like the Doctor to be aware of:

Number of dependent children: _____ Number of adult children: _____ □ Check box if pregnant or nursing

When did you start smoking: □ never □ year smoking began _____ □ year smoking ended _____ □ current smoker

Do you drink alcohol: □no □ less than 1 drink per day □ 1-2 per day □ more than 3 drinks per day

How did you hear about our office?_____

Your primary reason for today's visit is: _____

email address (this will only be used to confirm appointments, etc. and will never be shared):

_____

Person to contact in case of emergency:

Name_____

Address_____

_____

Phone_____

Relationship to you_____