Welcome To Our Office

CARMEL MOUNTAIN VISION CARE OPTOMETRY

Doctors of Optometry
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Patient Information

Dr. Mr. Rev. Ms. Miss. Mrs. Male Female Single Married Divorced Widowed

Date of Birth___/____/_____

Last Name_____ First Name_____ MI ____ Nickname_____

Address_____ City_____ State_____ Zip_____

Home#_____ Work#_____ Cell#_____

Email_____

Social Security#:_____

Employer (School):_____ Occupation (Grade):_____

Preferred form of communication *E-mail Postal Telephone*

How did you first find out about us? *Family, friend, or co-worker Doctor referral Eye care plan directory Internet Other*_____

If another person recommended us, whom may we thank? _____

Race Caucasian AA Hisp Asian Native Am. Other_____ **Ethnicity** Non- Hisp Hispanic

Insurance Information

Are you a member of an eye care plan? Yes No

Vision Service Plan (VSP) **Medical Eye Services (MES)** **EyeMed** **Other:** _____

Medical Insurance: **Blue Cross/Shield** **PacifiCare** **Cigna** **Aetna** **Medicare** **Other:** _____

Member: _____ Relation_____ DOB _____/_____/_____ ID/SSN_____

Personal Medical History

Primary care physician:_____ Phone:_____

Medication Allergies: None Penicillin Sulfa Drugs Codeine

List any Medications you currently take (*Including oral contraceptives, OTC medications, Aspirin, and home remedies)*

Medication: _____reason/ condition_____

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Medication: _____ reason/ condition_____

Reason for your visit today?

Eye health visit	Distance blur	Near blur	Laser vision correction Evaluation	Corneal Refractive Therapy (CRT) Eval	Vision Therapy
High definition glasses	Burning	Contact lens evaluation	Low vision evaluation	Headaches	Eyestrain
Double Vision	Loss of side vision	Night vision blur	Pressure around eyes	Dry sandy/gritty feeling	Watering
Eye Pain	Red eyes	Flashes/floaters	Itchy eyes	Light sensitivity	Fluctuating vision

Other (Describe) _____

Personal Health History

If Yes please explain

Allergic/Immunologic (hayfever, environmental)	Y N	_____
Cardiovascular (high blood pressure, cholesterol, stroke, heart)	Y N	_____
General constitution (fibromyalgia, obesity, anorexia, bulimia)	Y N	_____
Endocrine (diabetes mellitus, hypo- or hyper-thyroid, gout)	Y N	_____
Gastrointestinal (inflammatory bowel disease, Crohn's disease)	Y N	_____
Genitourinary (kidney failure, prostate/ovarian cancer, pregnant)	Y N	_____
Ear/ Nose/ Throat (hearing loss, sleep apnea, sinusitis)	Y N	_____
Blood (anemia, blood clotting disorders, sickle cell)	Y N	_____
Skin (eczema, acne rosacea)	Y N	_____
Muscle/ joints (osteoporosis, rheumatoid arthritis)	Y N	_____
Neurologic (migraine headaches, traumatic brain injury)	Y N	_____
Psychiatric (depression, memory loss, OCD)	Y N	_____
Respiratory (asthma, tuberculosis)	Y N	_____

OCULAR HEALTH HISTORY

Self			**Family**			**Relationship to you**
Glaucoma	Y	N	Glaucoma	Y	N	
Macular Degeneration	Y	N	Macular Degeneration	Y	N	
Cataracts	Y	N	Cataracts	Y	N	
Retinal	Y	N	Retinal	Y	N	
Optic Nerve Disease	Y	N	Diabetes	Y	N	
Eye Injury	Y	N	High blood pressure	Y	N	
Other	Y	N	Other	Y	N	

HISTORY OF EYE INJURIES OR SURGERIES

☐ Lasik ☐ PRK ☐ RK ☐ Intacts ☐ Eyelid ☐ Cataract ☐ Retinal ☐ Glaucoma Other: _____

Lifestyle/Social History

When was your last comprehensive vision exam? Never Less than 1year 1 year 2 year 3 year 4 year 5+ years

Do you wear glasses? Yes No ***If yes do you wear them*** Full Time Part Time Seldom

For what purpose were they prescribed? General Use Distance Only Near Only Computer Use Occupational Safety Sport

Do you wear contacts lenses? Yes No **Type of lens:** Soft Toric Gas Permeable Multifocal/Monovision CRT/Ortho-K Synergeyes

How often do you replace your lenses? Daily 2 weeks Monthly Annual Other **Do you sleep in your lenses?** Yes No

What is the brand of contact lenses worn? _____

Do you drive? Yes No ***If yes, do you have visual difficulty when driving?*** Yes No *Explain* _____

Do you drink alcohol? Yes No **How often?** Social Use 1-2 drinks daily Dependent

Do you use tobacco products? Yes No **Do you use recreational drugs?** Yes No

Height _____ ' _____ " **Weight** _____ **Birth order 1 2 3 4 Twin Other:**_____

Have you ever been exposed or infected with any of the following?

STD's	Y	N
HIV	Y	N
Blood Transfusion	Y	N
Hepititis A/B/C	Y	N

Please list hobbies you enjoy _____

Payments and Co-payments

All required payments, co-payments, deductibles, and other out-of-pocket expenses are due in full at the time services are rendered or materials are provided, unless specific financial agreements have been made prior to your scheduled appointment. The office accepts American Express, Visa, MasterCard, Debit cards and personal checks with proper identification. All personal checks returned for any reason are subject to a $25 service charge without exception. In the event of nonpayment, the cost of collection and/ or court costs and reasonable legal fees is the responsibility of the patient.

Vision Plan and Insurance Benefits

It is your responsibility to understand the nature of your vision plan and insurance benefits prior to your scheduled appointment. The employees of ***Carmel Mountain Vision Care Optometry*** will to the best of their knowledge and understanding help answer any questions you may have regarding your vision plan and insurance benefits; however, no guarantee of accuracy regarding eligibility, coverage, or benefit information can be made by anyone other than your vision plan or insurance carrier directly.

Assignment of Benefits

I authorize assignment of vision plan and insurance benefits to ***Carmel Mountain Vision Care Optometry*** for the purpose of determining eligibility, benefits, and collecting for all services rendered and materials provided. In addition, I authorize ***Carmel Mountain Vision Care Optometry*** and any of its employees to furnish information concerning my present condition to insurance companies and referring doctors as deemed necessary. I understand that I am responsible for any non-covered services by my insurance. I agree that I will not withhold or delay payment if my vision plan or insurance denies payment on any charges submitted by ***Carmel Mountain Vision Care Optometry***. I understand that ***Carmel Mountain Vision Care Optometry*** bills my vision plan and insurance as a courtesy. I acknowledge that failure to meet my financial obligations may result in the referral of my account to a collection agency.

Misses, Broken & Cancelled Appointments

If a scheduled appointment time is missed, broken, or cancelled for any reason without 24 hour notice, a fee of $25 may be assessed to your account. Please notify the office at least 48 hours in advance if you are unable to keep your appointment.

HIPPA Compliancy

I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPPA) for this office. I have read and understood the terms and conditions outlined above and herby certify that all of the information provided is true and accurate to the best of my knowledge and understanding.

Your Optomap retinal imaging fee will be $39 today (not covered by most insurances).

Signature _____ **Date** _____

○ Reserve my appointment for next year **TODAY** (you can change it later) ○ Remind me to schedule by mail