LAFONT FAMILY EYECARE OPTOMETRY

Welcome to our office! Please fill out the following. Your responses will be treated as confidential medical information.

Name (Last, First, M.I.) ______________________________

Nickname ____________________ ☐ Male ☐ Female

DOB (MM/DD/YY) _____/_____/_____ **Age** __ ___________

Address ______________________________

City ____________________ **State** _____ **Zip** __________

Home Phone (_____)______________________________

Work Phone (_____)____________________ **ext** _________

Cell Phone (_____)____________________ ☐ Ok to text

Email address ______________________________

How do you prefer to be contacted?

☐ Home ☐ Work ☐ Cell ☐ Email

Race

☐ American Indian/Alaska Native ☐ Asian

☐ Black/African American ☐ Native Hawaiian/Pacific Islander

☐ White

Ethnicity

☐ Not Hispanic or Latino ☐ Hispanic or Latino

Preferred Language ______________________________

Employer/School ______________________________

Occupation/Grade ______________________________

Hobbies ______________________________

How did you learn about our office? ____________________

Did you research our office online? How? ☐ Yes ☐ No

☐ Google ☐ Yelp ☐ Facebook ☐ Website ☐ Other

Vision Insurance

☐ VSP ☐ EYEMED ☐ SPECTERA ☐ MEDICARE ☐ NONE

☐ MES ☐ DAVIS ☐ CALOPTIMA ☐ OTHER

Subscriber Name ______________________________

Subscriber DOB _____/_____/_____ **SSN** _____-_____-________

Relationship to insured

☐ Self ☐ Spouse/Partner ☐ Child ☐ Other

Medical Insurance

Company ______________________________

☐ PPO ☐ HMO ☐ Kaiser ☐ Medicare ☐ Medi-cal

Subscriber Name ______________________________

ID# ______________________________

Emergency Contact:

Name ______________________________

Phone (_____)_______________ **Rel** ____________________

Eye and Medical History

What is the reason(s) for your visit?

____

Last Eye Exam (Date, Doctor) ______________________________

Do you currently wear glasses? ☐ Yes ☐ No

Do you experience any of the following symptoms?

(Check all that apply)

☐ Burning ☐ Itching ☐ Tearing/watering ☐ Blurry Vision

☐ Eyestrain ☐ Floaters ☐ Headaches ☐ Light Flashes

☐ Pain ☐ Glare ☐ Light Sensitivity ☐ Double vision

☐ Eye Irritation

Do you wear contact lenses? ☐ Yes ☐ No

If yes, which type? ☐ Soft ☐ Hard **Brand** ____________

Do you sleep in you contacts? ____________________

Have you ever had any eye injuries or surgeries?

☐ Yes ☐ No

If yes, please list type, eye and approximate date.

____

Who is your primary care doctor?

____

Are you being followed by a doctor for any of the following medical condition(s)?

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol

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Do <u>you</u> or any of <u>your relatives</u> have any of the following?

- ☐ Glaucoma? Who? ______
- ☐ Cataracts? Who? ______
- ☐ Macular Degeneration? Who? ______
- ☐ Retinal Disease / Detachment? Who? ______
- ☐ Blindness? Who? ______
- ☐ Strabismus (eye turn)? Who? ______
- ☐ Amblyopia? Who? ______
- ☐ Diabetes? Who? ______
- ☐ Dry Eye? Who? ______
- ☐ Cancer? Who? ______
- ☐ Heart Disease? Who? ______
- ☐ Hypertension? Who? ______
- ☐ High Cholesterol? Who? ______
- ☐ Stroke? Who? ______
- ☐ Thyroid Condition? Who? ______
- ☐ Other? Who? ______

Height ______ **Weight** ______

Do you smoke? ☐ Never ☐ Former ☐ Current

Do you drink alcohol? ☐ Socially ☐ Yes ☐ No

Please list all of the medications including eye drops you are currently taking, both prescription and over the counter:

______

______

______

Do you have any <u>allergies to medications</u>? ☐ Yes ☐ No

If yes, please list

______

Have you ever had an allergic reaction to drops used in an eye exam? ☐ Yes ☐ No

Do you have seasonal allergies/hay fever? ☐ Yes ☐ No

Do you have any other allergies? ☐ Yes ☐ No

If yes, please list ______

______

Lifestyle

Do you?

☐ Use a computer?	☐ Yes	☐ No	Hours/day ____
☐ Use smartphone/tablet	☐ Yes	☐ No	Hours/day ____
☐ Drive	☐ Yes	☐ No	Hours/day ____
☐ Drive at night	☐ Yes	☐ No	Hours/day ____
☐ Watch TV	☐ Yes	☐ No	Hours/day ____
☐ Play sports	☐ Yes	☐ No	Hours/day ____
☐ Spend time in sun	☐ Yes	☐ No	Hours/day ____

Are you interested in the following

(Check all that apply)

- ☐ Contact Lenses
- ☐ Glasses for computer/ hobbies
- ☐ Sunglasses
- ☐ Safety Glasses
- ☐ Sports Glasses
- ☐ Glasses for computer/ hobbies
- ☐ LASIK

Are you bothered by glare or reflection? ☐ Yes ☐ No

Acknowledgment of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations. The ***Notice of Privacy Practices*** describes these uses and disclosures in detail.
I acknowledge that I have been offered the *Notice of Privacy Practices* from LaFont Family Eyecare Optometry.

Signature ______ Date ______

Name ______