PLEASE ANSWER THE FOLLOWING QUESTIONS:

TODAY'S DATE___________________

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Last Name_______________________ First_______________________

Address_______________________ City_______________ State_________ Zip_______________

Home Phone_______________ Work Phone_______________ Cell Phone_______________

E-mail_______________________ Date of Birth_______________ Soc. Sec. #_______________

Occupation_______________________ Employer_______________________

ARE YOU A NEW PATIENT? ☐ **YES** ☐ **NO** **HOW WERE YOU REFERRED TO US?**

☐ Yellow Pages ☐ Saw the Office ☐ Recall Notice ☐ Coupon/Mailer ☐ Insurance Co. Website ☐ Other Internet _______________

☐ Other _______________________ ☐ Friend/Relative: Name_______________________

Date of last eye exam?_______________ Age of present glasses?___________ Age of present contact lenses?___________

Do you sleep in your lenses? ☐ Yes ☐ No How often do you dispose of your contacts?_______________

Interested in: New contact lenses? ☐ Yes ☐ No Laser surgery? ☐ Yes ☐ No Sports eyewear? ☐ Yes ☐ No

INSURANCE ASSIGNMENT AND HEALTH AUTHORIZATION

Your signature below signifies that you consent to the use and disclosure of your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. You have the right to ask us to restrict the use of this information.

I assign my insurance benefits payable to **Del Amo Optometry** Signature_______________________

Please note: In the event that benefits aren't paid by the insurance carrier, the entire balance is your responsibility.

VISION INSURANCE

☐ Vision Service Plan (VSP) ☐ Medi-Cal ☐ Union ☐ Medicare

☐ Other Insurance (please specify)_______________________

IF INSURED IS OTHER THAN SELF, LIST **INSURED** INFORMATION: Relationship_______________________

Name_______________________ Birthdate_______________ Soc. Sec. #_______________

PRIMARY MEDICAL INSURANCE

☐ HMO ☐ PPO ☐ POS Other (please specify)_______________

Carrier_______________________ ID#_______________________ Phone_______________________

Name of family Doctor_______________________ Phone_______________________

DO YOU OR YOUR FAMILY HAVE (please circle)**:**

Cataracts?	Self	Family	None
Glaucoma?	Self	Family	None
Eye Surgery?	Self	Family	None
Headaches?	Self	Family	None
Diabetes?	Self	Family	None
High Blood Pressure?	Self	Family	None
Thyroid Problems?	Self	Family	None
Cataract Surgery?	Self	Date(s) _________	
Other Eye Surgery or Condition?_______________			
Dry or irritated eyes?	Occasionally	Frequently	

DO YOU (please circle)**:**

Drink Alcohol?	Yes	No
Smoke Tobacco?	Yes	No
Use Other Substances?	Yes	No

Allergies_______________________

Medications_______________________

____

Hobbies_______________________

Computer use per day?_________ hours

HOW WOULD YOU LIKE US TO CONTACT YOU IN THE FUTURE: ☐ Phone ☐ Mail ☐ Email_______________

Date___________ Changes_______________________ Sig_______________________

___________ _______________________ _______________________

___________ _______________________ _______________________