SAN DIEGO CENTER for VISION CARE-

Optometry,P.C.

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WELCOME TO THE SAN DIEGO CENTER FOR VISION CARE

To do our best to help you, please complete this form carefully.

Full Name _____ Male _____ Female _____
Birth Date _____ Age: _____
Address _____
Telephone Number(s) (Hm) _____ (Wk) _____ (Cell) _____
E-mail address: _____
How did you choose our office? _____
Were you referred? Yes _____ No _____
If yes, by whom? _____ Phone _____
Address _____
Do you have major medical insurance? _____ Do you have a flex spending account? Y N
If yes, who is the carrier?_____ Policy # _____
Name of Insured _____
Social Security # (last four) _____ Driver's License No. _____
Does your insurance cover eye examinations or eyeglasses? Yes _____ No _____
What is your occupation? _____
Employer: _____
Please list the names and birth dates of your spouse and dependents:

	NAME(S)	
Spouse	_____	Birth Date _____
Dependent(s)	_____	Birth Date _____
	_____	Birth Date _____
	_____	Birth Date _____
	_____	Birth Date _____

MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

	Patient	Family		Patient	Family
Diabetes	_____	_____	High Blood Pressure	_____	_____
Blindness	_____	_____	Eye Infections	_____	_____
Eye Turns	_____	_____	Thyroid Condition	_____	_____
Glaucoma	_____	_____	Eye Surgery	_____	_____
Cancer	_____	_____	Cataracts	_____	_____
			Macular Degeneration	_____	_____

Physician's Name _____ Date of Last Visit _____
Medications currently using: _____
For what condition?_____
Are you allergic to any foods or medicines? .....Yes _____ No _____

If yes, please list: _____

Do you use cigarettes/tobacco? .....Yes _____ No _____

Do you drink alcohol? .....Yes _____ No _____

Do you use other substances? .....Yes _____ No _____

VISUAL HISTORY

Main reason for having an examination today: _____

Date of Last Visit: _____ Doctor's Name: _____

Reason for last examination: _____

Results: _____

VISUAL HISTORY (con't)

Were glasses prescribed? .....Yes _____ No _____

If yes, how often do your wear them?_____

Any problems with your current glasses?_____

Do you wear contact lenses?.....Yes _____ No _____

If yes, how long have you worn them?_____

How old are your current contact lenses? _____

What solutions do you use? _____

Do you experience any of the following:

	Yes	No	If yes, when?
Headaches	_____	_____	_____
Blurred vision	_____	_____	_____
Double vision	_____	_____	_____
Eyes "hurt" or tired"	_____	_____	_____
Eyes itch	_____	_____	_____
Eyes burn	_____	_____	_____
Eyes tear	_____	_____	_____
Eyes frequently reddened	_____	_____	_____
Closing or covering one eye	_____	_____	_____
Lose place while reading	_____	_____	_____
Poor reading comprehension	_____	_____	_____
When reading, letters/words appear to move or float around	_____	_____	_____

List any other complaints concerning your vision: _____

_____

Do you use a computer?.....Yes _____ No _____

If yes, how many hours a day? _____

Please enter the following computer work distances:

Eyes to the: Screen _____ Keyboard _____ Source Document _____

Please describe any problems you have with your current glasses or contact lenses for computer work:

_____

Any visual symptoms after using your computer? _____

_____

OFFICE POLICIES

FEES: You are expected to pay for services and materials at the time of your examination.

INSURANCE: Please be sure to notify the staff if you have vision insurance.

VISION SERVICE PLAN/MEDICAL EYE SERVICES: VSP and MES are billed directly. We will help you to the fullest extent possible when submitting claims to other insurance carriers.

RELEASE OF INFORMATION AND INSURANCE FILING

I agree to permit information from, or copies of, my examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of the San Diego Center for Vision Care, Optometry - P.C. when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. I release payment of benefits to myself or to the San Diego Center for Vision Care, Optometry - P.C.

_____ _____

Signature or Authorized Representative Date

Thank you for carefully completing this questionnaire. Your vision care is very important to us. Please do not hesitate to ask any questions you may have. We encourage you to call us anytime if you have questions about your or your family's vision.