WELCOME TO SEAL BEACH EYES!

(562) 431-2031 www.sealbeacheyes.com

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. **Last name**______________________________ **First name**______________________________ **MI**____

Address____ **City**__________________________ **Zip**_______________

Telephone (H) __________________________ **(W)** __________________________ **(Cell/Other)** __________________________

E-mail address ____ **How did you hear about our office?**______________________

SSN_______________________ **Date of Birth**_______________________ **Age**________ **Sex** ☐ **Male** ☐ **Female**

Marital Status ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Other** **Spouse's name**____________________________

Employment ☐ **Full-Time** ☐ **Part-Time** **Occupation** ________________________ **Company** ___________________________

Previous Eye Doctor____ Date of Last Visit____________________________

Medical History

Check any of the following that apply to the patient:

☐ **AIDS/HIV** ☐ **Kidney Disease**
☐ **Headaches** ☐ **Stroke**
☐ **Heart Disease** ☐ **High Blood Pressure**
☐ **Thyroid Condition** ☐ **Diabetes (Type__)**
☐ **Cancer (Explain)** ___________________________
☐ **Other (Explain)** ___________________________
☐ **Operations/Surgery** ___________________________
____
☐ **Cigarettes/Tobacco** ☐ **Alcohol** ☐ **Pregnant**

Ocular History

Check any of the following that apply to the patient:

☐ **Blurred Vision** ☐ **Floaters or Spots** ☐ **Double Vision**
☐ **Dry Eyes** ☐ **Itchy Eyes** ☐ **Tearing** ☐ **Other**_________________
☐ **Eye Operation (Explain/Date):** _________________________
☐ **Eye Injury (Explain/Date):** ______________________________

Glasses ☐ **None** ☐ **Reading** ☐ **Distance** ☐ **Computer**
☐ **Bifocals (Lined)** ☐ **Trifocals** ☐ **Progressives (No Line)**

Contact Lenses ☐ **Soft Lenses** ☐ **Toric Lenses** ☐ **RGP**

Type/Brand _________________________ **BC**______ **DIA**______

Hours/Day_________ ☐ **Sleep in lenses** ☐ **Do not sleep in lenses**

Current Medications (including eye drops)

☐ **None** _______________________________________
____
____
____

Allergies: _____________________________________
____
____

Family History

Check any of the following that apply and state the relation to the patient:

	Relation:
☐ **Vision Loss**	______________________
☐ **Glaucoma**	______________________
☐ **Macular Degeneration**	______________________
☐ **Retinal Detachment**	______________________
☐ **Diabetes (Type__)**	______________________
☐ **Other**________________	______________________

Insurance Information

VISION PLAN ___________________________________
ID# ____
Subscriber ______________________________________
☐ Self ☐ Parent ☐ Spouse **Date of Birth**_______________

MEDICAL PLAN __________________________________
ID# ____
Subscriber ______________________________________
☐ Self ☐ Parent ☐ Spouse **Date of Birth**_______________

Assignment and Release

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I hereby authorize this vision care provider to apply for benefits on my behalf for covered services rendered and request that all payments be made directly to the vision care provider. I agree to assume all responsibility of full charges whether or not paid by insurance. I further authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE X____ **Date** _______________

Health Insurance Portability and Accessibility Act – ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICE

It is often necessary to use and disclose health information that identifies you in order to treat you, to obtain payment for our services, and, to conduct healthcare operations involving our office. The Notice of Privacy Practices describes these uses and disclosures in detail. Our office is in full compliant with HIPAA, and a copy of the Notice of Privacy Practice is available if you'd like a copy for your records.

SIGNATURE X____ **Date** _______________