CORONADO
family optometry

PATIENT INFORMATION FORM

Mr. Mrs. Ms. Dr. Child Date: ___/___/___

Name: _____
Last First Middle

Birth Date: ____/____/____ Age: _____ Sex: □ Male □ Female

Address: _____
Street, Apt # City, State Zip

Cell (_____)_____ **Email**_____

Other (_____)_____ Social Security_____

How did you hear about us? □ Insurance Friend/Family Walk-In Previous Patient
□ Other_____

INSURANCE INFORMATION

Name of Insurance _____

Insured's ID# or SS#_____

Insured's Name _____ Relationship to Patient _____

Insured's Birth Date _____

I authorize payment of medical benefits to Coronado Family Optometry I understand that I am financially responsible to the provider for charges not covered by this authorization (non-covered services) as well as any deductible and/or co-insurance and that payment for these services is expected on the day the service is rendered.

Initials _____

Due to the Health Insurance Portability and Accountability Act (HIPAA), we are obligated by law to give you notice of our privacy practices. I acknowledge that I read and understand Coronado Family Optometry's Notice of Privacy Practices, and will be given a copy per my request.

Initials _____

Signature_____ Date ____/____/____

TURN OVER AND COMPLETE THE OTHER SIDE

PLEASE COMPLETE THE FOLLOWING HEALTH HISTORY

Reason for today's visit: _____

Occupation:_____ When was your last eye exam?_____ Where?_____

Do you presently wear glasses? Yes No Full time Part-time

Do you wear contact lenses? Yes No If yes, what brand? _____

Are you experiencing any of the following eye/vision problems? (*Please check all that apply*)

Itchy eyes	Watery eyes	Flashes
Pain/Soreness	Tired eyes	Floaters
Red Eye	Light Sensitivity	Headaches
Burning Stinging	Blurred Vision	Previous eye injury _____
Discharge	Double Vision	Previous eye surgery _____
Dryness/Sandy/Gritty	Loss of Vision	Other (describe) _____

Have **YOU** ever been diagnosed as having any of the following? (*Please check all that apply*)

□ Cataracts	□ Diabetes
□ Glaucoma	□ High Blood Pressure
□ Macular Degeneration	□ Cancer
□ Lazy Eye	□ Cholesterol
□ Retinal Detachment/Disease	□ Thyroid
□ Respiratory	□ Other (describe) _____

Has **ANYONE IN YOUR FAMILY** ever been diagnosed as having any of the following?

□ Blindness	□ Diabetes
□ Macular Degeneration	□ High Blood Pressure
□ Retinal Detachment/Disease	□ Cancer
□ Glaucoma	□ Heart Disease

Are you currently taking any medications? (Prescription, non-prescription, home remedies, vitamins) □ **NONE**

1. _____	3. _____	5. _____	7. _____
2. _____	4. _____	6. _____	8. _____

Do you have any **allergies** to medication/anesthesia or anything else? Circle one: **NO** or **YES (if yes list below)**

_____

Do you smoke?	Yes	No
Are you pregnant?	Yes	No
Are you interested in finding out about contact lens options for yourself?	Yes	No
Are you interested in finding out about laser vision correction?	Yes	No

Signature:_____ **Date:** _____