TORRANCE OPTOMETRY

Patient Information and History

Title: Mr. Mrs. Ms. Dr. Sex: Male Female Date of Birth: _____/_____/_____

Marital Status: Single Married Divorced Widowed Primary Language: _____

Birth Place: _____ Race/Ethnicity (optional): _____

Last Name: _____ First Name: _____ Middle Initial _____

Address: _____ City _____ State _____ Zip Code _____

Home # (_____) _____ Work # (_____) _____ Cell # (_____) _____

Please circle preferred contact #: Home Work Cell Other_____

E-mail Address:

Employer Name: _____ Occupation: _____

SSN (at least last 4 digits): _____ If you were referred to our office, by whom? _____

Spouse's Name: _____ Spouse's Employer _____

PATIENT INSURANCE INFORMATION

Vision Insurance: VSP EyeMed MES Davis Vision Medi-Cal Medicare Other _____

Primary Member Name _____ Date of Birth ____/____/_____ Member ID/SSN _____

Relationship to Patient: Self Dependent Spouse

Secondary Member Name _____ Date of Birth ____/____/____ Member ID/SSN _____

Relationship to Patient: Self Dependent Spouse

Medical Insurance Provider: _____ Member ID #: _____

PATIENT HISTORY

Last Physical Exam: ____/____/_____ Name of Medical Dr. _____

Medical Dr. Contact #_____ Address: _____

Last Eye Examination: Never 1-2 yr 3-4 yr 5+ yr Previous Dr. _____

Primary reason for today's visit: Routine Exam Contact Lens LASIK consult Other_____

Do you wear glasses? Yes No If yes, how old are your current pair of lenses? _____

Do you wear contact lenses? Yes No If no, are you interested in contact lenses? Yes No

If yes, what type? Soft Gas Permeable (Hard) Toric (Astigmatism) Multifocal Monovision

Do you work on a computer? Yes No If yes, how many hours a day? _____

Do you experience problems with glare? Yes No Do you wear sunglasses outdoors? Yes No

Do you drive? Yes No If yes, on average how many miles a day? _____

Hobbies _____ Occupational Requirements _____

TORRANCE OPTOMETRY PAYMENT POLICIES

Payment for professional services is due in full when services are rendered. All professional services and materials will be charged directly to the patient unless indicated below.

The undersigned accepts full responsibility for any bill incurred in this office, regardless of insurance(s). Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. Payment from my insurance is to be paid directly to Torrance Optometry.

Printed Name: _____ Signature: _____ Date ___/____/_____

If someone other than the patient is responsible for this account, please complete the following:

Responsible Individual's Last Name: _____ First Name: _____

Relationship to the patient _____ Preferred title: Mr. Ms. Mrs. Dr.

Address _____ City _____ State _____ Zip Code_____

Please sign for patients under the age of 18:

As legal guardian, I give my permission for _____ to have his/her eyes examined and services provided by the doctors at Torrance Optometry.

Signature: _____

FAMILY HISTORY – Please circle if you or your family has experienced any of these conditions.

				Family Relationship
Glaucoma	Self	No	Yes	_____
Cataracts	Self	No	Yes	_____
Macular Degeneration	Self	No	Yes	_____
Eye Injuries	Self	No	Yes	_____
Retinal Disease/Detachment	Self	No	Yes	_____
Blindness	Self	No	Yes	_____
Crossed Eyes/Strabismus	Self	No	Yes	_____
Lazy Eye/Amblyopia	Self	No	Yes	_____
Diabetes	Self	No	Yes	_____
Dry Eyes	Self	No	Yes	_____
Eye/Refractive Surgery	Self	No	Yes	_____
Cancer	Self	No	Yes	_____
Heart Disease/High Blood Pressure	Self	No	Yes	_____
Multiple Sclerosis	Self	No	Yes	_____
Lupus/Sarcoid	Self	No	Yes	_____
Thyroid Disease	Self	No	Yes	_____
Other_____	Self	No	Yes	_____

REVIEW OF SYSTEMS – Please circle if you currently or have ever had any problems in the following areas.

Constitution			**Gastrointestinal**			**Endocrine**		
Nausea	Yes	No	Reflux	Yes	No	Hypo/Hyper Thyroid	Yes	No
Flu-like Symptoms	Yes	No	Stomach/Intestine	Yes	No	Diabetes	Yes	No
Cardiovascular			**Genitourinary**			**Hematologic**		
Heart Disease	Yes	No	STD	Yes	No	Leukemia/Lymphoma	Yes	No
High Blood Pressure	Yes	No	Kidney	Yes	No	Anemia	Yes	No
High Cholesterol	Yes	No	**Musculoskeletal**			Bleeding Disorder	Yes	No
Pacemaker	Yes	No	Arthritis	Yes	No	**Eyes**		
Ear, Nose, Mouth, Throat			MS	Yes	No	Vision Loss	Yes	No
Hearing Loss	Yes	No	Joint Pain	Yes	No	Double Vision	Yes	No
Sinus Congestion	Yes	No	**Integumentary**			Flashes/Floaters	Yes	No
Dry Mouth/Throat	Yes	No	Eczema	Yes	No	Chronic Infection	Yes	No
Respiratory			**Neurological**			Stye/Chalazion	Yes	No
Asthma	Yes	No	Headaches/Migraines	Yes	No	Light Sensitivity	Yes	No
COPD	Yes	No	Seizures	Yes	No	**Psychiatric**	Yes	No
TB	Yes	No	Stroke	Yes	No	**Immunologic**		
						Allergies-Seasonal	Yes	No
						Allergies-Other	Yes	No
Other: _____						Lupus	Yes	No

Social History: Are you pregnant or nursing? Yes No If yes, due date:_____

Have you ever used any form of: alcohol recreational drugs If so, how often _____

Have you ever used tobacco: Yes No (Former User) No If so, how often _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis Other_____

List of Medications:	For what Condition:	List of Allergies to Medications:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____