WELCOME

FULLERTON VISION CENTER

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

PATIENT INFORMATION

Today's Date:_____

Patient Name: _____

Address: _____

_____

E-Mail: _____

Note: We are making greater use of e-mail to communicate with our patients. Your address is never shared and all information is kept strictly confidential.

Cell Phone: _____

Home Phone: _____

Work Phone: _____Ext: _____

Sex ☐ M ☐ F Age: _____ Birthdate: _____

Social Security #: _____

Occupation: _____

Whom may we thank for your referral? _____

INSURANCE INFORMATION

Person responsible for account: _____

Relationship To Patient:_____Birthdate:_____

Social Security #: _____

Address (if different from patient's): _____

_____

Insurance Co.: _____Group #: _____

Subscriber ID #: _____

INSURANCE AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with_____ and assign
Name of Insurance Company
directly to FULLERTON VISION CENTER all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____ _____
Signature of Insured / Parent / Guardian or Personal Representative Date

MEDICAL HEALTH HISTORY

Name of Medical Doctor: _____
Last Medical Exam:_____Last Eye Exam:_____

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐Yes ☐No How old are your glasses? _____
☐ All the time ☐ Reading ☐ Driving ☐ Occasionally

Do you wear contacts? ☐Yes ☐No How old are your contacts? ___
Type of contact: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other

Describe any problems you have with your contacts?_____

_____

Do you ever suffer from red, itchy, watery eyes? ☐Yes ☐No

Do you ever use an over-the-counter eye drop (Visine A, Visine AC, Opcon A, etc.) to treat red, itchy, watery eyes? ☐Yes ☐No

Do you take oral medication like Claritin, Allegra, or Zyrtec for allergies? ☐ Yes ☐ No

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Fullerton Vision Center for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ _____
Lifetime Patient Signature Date

Do you have any Allergies to Medications? ☐ Yes ☐ No If yes, explain_____

_____

Please mark "Yes" or "No" if you have had and/or blood relative has had any of the following problems:

	Yourself	Family Members		Yourself	Family Members
Blindness	☐ Yes ☐ No	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Retinal Detachment	☐ Yes ☐ No	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	☐ Yes ☐ No
Retinal Disease	☐ Yes ☐ No	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No	☐ Yes ☐ No
			High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No

*** Please Turn This Form Over and Complete Side Two ***

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. If you do, please check the box marked yes.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
If yes, please describe: _____
Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____
Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long: _____
Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long: _____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently or have you ever had any problems in the following areas:

SYSTEM	YES	NO
CONSTITUTIONAL		
Fever, Weight Loss / Gain	☐	☐
INTEGUMENTARY (SKIN)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Sties or Chalazion	☐	☐
Flashes / Floaters in Vision	☐	☐
Tired Eyes	☐	☐
ENDOCRINE		
Thyroid / Other Glands	☐	☐

	YES	NO
EARS, NOSE, MOUTH, THROAT		
Allergies / Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat / Mouth	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR / CARDIOVASCULAR		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals / Kidney / Bladder	☐	☐
BONES / JOINTS / MUSCLES		
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐
PSYCHIATRIC	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain: _____

_____

_____

List any medications you take(including oral contraceptives, aspirin, over the counter medications):

_____

_____

_____ _____
Signature **Date**

☐ No change to Medical History _____ _____
Signature Date

☐ No change to Medical History _____ _____
Signature Date