PATIENT INFORMATION

Roseville Vision Center
1213 Pleasant Grove Blvd,
Roseville, CA 95678
(916)789-1959

PATIENT

Last Name | **First Name** | **MI** | ☐ **Male** ☐ **Female** | **Date of Birth** | **Age**

ADDRESS

Street Address | **City** | **State** | **Zip Code**

CONTACT

Cell Phone | **Texting OK?** ☐ **Yes** ☐ **No** | **Home Phone** | **Email Address**

INSURANCE

Medical Insurance
☐ **PPO** ____________________
☐ **HMO** ____________________

Vision Insurance
☐ **VSP** ☐ **EYEMED** ☐ **MES**
☐ **OTHER:** ____________________

Social Security/Member ID

WORK

Employer | **Occupation** | **Hobbies/Special Vision Requirements**

How did you hear about us? ☐Internet Search ☐Insurance Website ☐Another Patient: ________________ ☐Other:______________

Due to the complexity of insurance billing, we assist you in doing so. We will give you the best estimate of your out of pocket expenses, however, it is your responsibility to understand your coverage. Signing below authorizes the doctor to release any information including the diagnosis and/or records of any treatments rendered to you or your child to third party payers and/or other health care providers.

Signature (Parent/Guardian if under 18): ________________________________ **Date:** ______________

HEALTH HISTORY

List allergies to medications: ____

Primary Care Physician/Location: ____

List current medications (including over the counter, herbals, vitamins):______________________________
____

Do you use tobacco products, drink alcohol, or use illegal drugs? If so, please indicate type, amount and frequency:
☐ Yes: ____ ☐ No ☐ Will discuss with doctor

Have ever been exposed to or infected with?: ☐ Tuberculosis ☐ Hepatitis ☐ HIV ☐ Gonorrhea ☐ Syphilis

Are you currently pregnant or breastfeeding? ☐ Yes

List major surgeries/injuries/hospitalizations:____

EYE HISTORY (if yes, please explain)

Date of last eye exam if not here: __________ Age of current glasses:________ Prior doctor:____________________

Reason for leaving prior doctor:____

List anything unique about current lenses (prism, near use only, etc.):______________________________

Have your eyes ever been dilated? If so, when? ☐ No ☐ Yes:______________________________

Have you ever had an eye disease/injury/surgery to your eye? ☐ No ☐ Yes: ____________________

Have you ever seen flashes of light/floaters? ☐ No ☐ Yes: ____________________

Does/did one of your eyes turn in or out? ☐ No ☐ Yes: ____________________

Do you ever see double? ☐ No ☐ Yes: ____________________

Do you have frequent or severe headaches? ☐ No ☐ Yes: ____________________

Do you have difficulty with night vision/driving? ☐ No ☐ Yes: ____________________

Check box if you have: ☐ Dry eyes ☐ Eye allergies

Number of hours per day on a computer: _____

If you wear contacts, indicate type: ☐Soft ☐Toric ☐Multifocal ☐ Rigid

FAMILY HISTORY: Please indicate WHO (self or relative i.e. mother, father) has any of the following:

☐Diabetes: ____________________
☐High Blood Pressure: _____________
☐Heart Disease: _______________
☐Thyroid Problems: _____________
☐Asthma/Lung Disease: ___________
☐Glaucoma: ______________________
☐Macular Degeneration: ____________
☐Retinal Detachment: ______________
☐Cataracts: ______________________
☐Other: _________________________

RETURNING PATIENTS ONLY: Please indicate any changes since your last visit, then sign and date.

X: ______________________________________ Date: ____________________

X: ______________________________________ Date: ____________________

X: ______________________________________ Date: ____________________