LAFONT FAMILY EYECARE OPTOMETRY

Welcome to our office! Please fill out the following. Your responses will be treated as confidential medical information.

Name (Last, First, M.I.) _____

Nickname _____ □ Male □ Female

DOB (MM/DD/YY) _____/_____/_____ **Age** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone (____)_____

Work Phone (____)_____ **ext** _____

Cell Phone (____)_____ □ Ok to text

Email address _____

How do you prefer to be contacted?

□ Home □ Work □ Cell □ Email

Race

□ American Indian/Alaska Native □ Asian

□ Black/African American □ Native Hawaiian/Pacific Islander

□ White

Ethnicity

□ Not Hispanic or Latino □ Hispanic or Latino

Preferred Language _____

Employer/School _____

Occupation/Grade _____

Hobbies _____

How did you learn about our office? _____

Did you research our office online? How? □ Yes □ No

□ Google □ Yelp □ Facebook □ Website □ Other

Vision Insurance

□ VSP □ EYEMED □ SPECTERA □ MEDICARE □ NONE

□ MES □ DAVIS □ CALOPTIMA □ OTHER

Subscriber Name _____

Subscriber DOB ____/_____/_____ **SSN** _____-_____-_____

Relationship to insured

□ Self □ Spouse/Partner □ Child □ Other

Medical Insurance

Company _____

□ PPO □ HMO □ Kaiser □ Medicare □ Medi-cal

Subscriber Name _____

ID# _____

Emergency Contact:

Name _____

Phone (_____)_____ **Rel** _____

Eye and Medical History

What is the reason(s) for your visit?

_____

Last Eye Exam (Date, Doctor) _____

Do you currently wear glasses? □ Yes □ No

Do you experience any of the following symptoms?

(Check all that apply)

□ Burning □ Itching □ Tearing/watering □ Blurry Vision

□ Eyestrain □ Floaters □ Headaches □ Light Flashes

□ Pain □ Glare □ Light Sensitivity □ Double vision

□ Eye Irritation

Do you wear contact lenses? □ Yes □ No

If yes, which type? □ Soft □ Hard **Brand** _____

Do you sleep in you contacts? _____

Have you ever had any eye injuries or surgeries?

□ Yes □ No

If yes, please list type, eye and approximate date.

_____

Who is your primary care doctor?

_____

Are you being followed by a doctor for any of the following medical condition(s)?

□ Diabetes □ High Blood Pressure □ High Cholesterol

LAFONT FAMILY EYECARE OPTOMETRY

Do you or any of your relatives have any of the following?

□ Glaucoma? Who? _____

□ Cataracts? Who? _____

□ Macular Degeneration? Who? _____

□ Retinal Disease / Detachment? Who? _____

□ Blindness? Who? _____

□ Strabismus (eye turn)? Who? _____

□ Amblyopia? Who? _____

□ Diabetes? Who? _____

□ Dry Eye? Who? _____

□ Cancer? Who? _____

□ Heart Disease? Who? _____

□ Hypertension? Who? _____

□ High Cholesterol? Who? _____

□ Stroke? Who? _____

□ Thyroid Condition? Who? _____

□ Other? Who? _____

Height _____ **Weight** _____

Do you smoke? □ Never □ Former □ Current

Do you drink alcohol? □ Socially □ Yes □ No

Please list all of the medications including eye drops you are currently taking, both prescription and over the counter:

_____

_____

_____

Do you have any allergies to medications? □ Yes □ No

If yes, please list

_____

Have you ever had an allergic reaction to drops used in an eye exam? □ Yes □ No

Do you have seasonal allergies/hay fever? □ Yes □ No

Do you have any other allergies? □ Yes □ No

If yes, please list _____

_____

Lifestyle

Do you?

□ Use a computer?	□ Yes	□ No	Hours/day _____
□ Use smartphone/tablet	□ Yes	□ No	Hours/day _____
□ Drive	□ Yes	□ No	Hours/day _____
□ Drive at night	□ Yes	□ No	Hours/day _____
□ Watch TV	□ Yes	□ No	Hours/day _____
□ Play sports	□ Yes	□ No	Hours/day _____
□ Spend time in sun	□ Yes	□ No	Hours/day _____

Are you interested in the following

(Check all that apply)

□ Contact Lenses

□ Glasses for computer/ hobbies

□ Sunglasses

□ Safety Glasses

□ Sports Glasses

□ Glasses for computer/ hobbies

□ LASIK

Are you bothered by glare or reflection? □ Yes □ No

Acknowledgment of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations. The ***Notice of Privacy Practices*** describes these uses and disclosures in detail.
I acknowledge that I have been offered the *Notice of Privacy Practices* from LaFont Family Eyecare Optometry.

Signature _____ Date _____

Name _____