WELCOME TO LA HABRA HILLS OPTOMETRY, INC.

Patient's Name(Mr/Mrs/Ms/Dr): _____ Today's Date: _____

Name you go by (if different): _____ Gender (M) (F) Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ ZipCode: _____

E-Mail: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Preferred Contact (please circle): Home Business Cell Other: _____

Occupation: _____ Place of Employment: _____

In case of emergency, contact: _____ Phone: _____

Date of Last Eye Exam (if at another office) _____ from Dr. _____

Have you ever had your eyes dilated? (Yes) (No) If yes, Date of Last Dilation Exam: _____

Reason for today's visit: _____

Will you be ordering new glasses today? (Yes) (No)

Are you interested in contact lenses? (Yes) (No) (Maybe)

Are you interested in acquiring information about LASIK? (Yes) (No)

Activities/Hobbies that require special vision care:

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:

(1) Another Patient (name): _____ (2) Family member: _____

(3) Phone Book (which book?): _____ (4) Doctor Referral (name): _____

(5) Insurance Coverage: _____ (6) Our Location: _____

(7) Internet. (Which website?): _____ (8) Other: _____

MEDICAL AND OCULAR HISTORY

Medical Doctor: _____ Last Visit: _____ Phone: _____

Do you have any of the following conditions? (If yes, please circle)

◊ Auto Immune Disease
◊ Cancer
◊ Diabetes
◊ Headaches
◊ Heart Disease
◊ High Blood Pressure
◊ Kidney Disease
◊ Lung Disease
◊ Dry Eyes
◊ Eye Injury
◊ Eye Surgery
◊ Glaucoma
◊ Loss of Vision or Blindness
◊ Macular Degeneration
◊ See Spots/Flashes of light
◊ Pregnant or Nursing
◊ Neurological Problems
◊ Pregnant or Nursing
◊ Sinus Problems
◊ Stomach Problems
◊ Blur with glasses
◊ Cataracts
◊ Detached Retina
◊ Double vision

Other Eye problems: _____

Other Medical Problems: _____

Does anyone in your family have any of the following conditions? (if yes, please circle)

◊ Auto Immune Disease
◊ Cancer
◊ Diabetes
◊ Headaches
◊ Heart Disease
◊ High Blood Pressure
◊ Kidney Disease
◊ Lung Disease
◊ Neurological Problems
◊ Sinus Problems
◊ Cataracts
◊ Detached Retina
◊ Eye Surgery
◊ Glaucoma
◊ Loss of Vision or Blindness
◊ Macular Degeneration
◊ Strabismus (eye turn)

Other Medical Problems: _____

Other Eye Problems: _____

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Are you taking any medications? If so, please list:

_____

_____

Are you allergic to any medications? If so, please list:

_____

_____

INSURANCE INFORMATION

Name of Vision Insurance: (please circle)

Vision Service Plan (VSP)	Medical Eye Services	Spectera/OptumHealth
Blue Cross	March Safeguard	Medi-Cal
Blue Shield	Medicare	EyeMed
Tricare	Other: _____	

Member's Name (if not self): _____ Member's Insurance/I.D. Number: _____

Member's Social Security Number: _____ Group Number: _____

Patient's relationship to member: ☐ self ☐ spouse ☐ child ☐ other

Patient's Status: ☐ single ☐ married ☐ other

☐ employed ☐ full-time student ☐ part-time student

Member's (if not self) date of birth:

Member's (if not self) place of employment:

Benefits will be verified before services are rendered. Verification of eligibility does not guarantee payment for services. All co-payments, deductibles, and/or fees for services not covered by the insurance plan are due at the time that services are rendered. If benefits cannot be verified at the time of service, the usual and customary fee is due in full by the person responsible for the account, and it is the insured's responsibility to collect any benefits from their insurance company directly. Please note that contact lens fittings/evaluations are not covered services for most insurance plans.

I request that payment of authorized insurance benefits be made on my behalf to La Habra Hills Optometry, Inc. for any services furnished to me. I authorize any holder of medical information about me to be released to the Center for Medicare & Medicaid services (CMS) and its agents and any information needed to determine these benefits or the benefits payable for related services. I understand that verification of eligibility does not guarantee payment for services. I agree to be fully and personally liable for payment if benefits are denied.

With this written authorization, I am accepting charges for services rendered that are not covered by my insurance and agree to pay for the services when rendered.

I acknowledge that I have received a copy of the La Habra Hill Optometry Inc.'s Notice of Privacy Practices, available from the office receptionist, also available for review/download from the office website: www.lahabrahillsoptometry.com

Patient / Guardian's Signature: _____ Date: _____