GARDEN GROVE FAMILY OPTOMETRY

Welcome to our office! Please print. All responses are confidential medical information.

Name (Last, First, M.I.) _____Sex: □ Male □ Female

DOB (MM/DD/YY) /_____ Age (Edad)_____ SS# (Seguro Social) XXX-XX-__ __ __ __

Address (Domicilio) _____

City_____ State _____Zip_____Daytime Phone:_____

Home Phone: _____Cell Phone ( )_____Ok to text? Y/N

Email address: _____ Ok to Email? Y/N

How do you prefer to be contacted? (Su contacto preferido) □ Home □ Work □ Cell □ Email

Employer/School: _____Occupation/Grade: _____

How did you hear about our office? _____(Patient/friend/relative/insurance/website/Google) (Como supo de nuestra oficina?)

Did you research our office online? YES/NO □ Google □ Yelp □ Facebook □ Website □ Other

Vision Insurance (Aseguranza de vision)

□ VSP □ EYEMED □ SPECTERA □ MEDICARE □ NONE □ MES □ DAVIS □ CALOPTIMA □ OTHER

Subscriber Name: _____ Subscriber DOB: ___ /____/____

SSN/ID_____

Relationship to insured: □ Self □ Spouse/Partner □ Child □ Other

Medical Insurance (Aseguranza de salud)

Name: _____□ PPO □ HMO □ Kaiser □ Medicare □ Medi-cal

Subscriber Name:_____DOB:_____SS/ID# _____

Emergency Contact: (En caso de emergencia, nombre para contactar)

Name: _____Phone ( )_____Relationship_____

Acknowledgement 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 *Garden Grove Family Optometry.***

Signature_____Name:_____Date_____

I authorize insurance payment directly to the doctor, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges for services rendered. I agree in the event of non-payment, to bear the cost of legal fees should this be required. I authorize the release of any medical information necessary to process this claim.

SIGNATURE/ (Firma) : _____ DATE/(Fecha): _____

For office use only:
RECALL:_____

NOTES: _____

Eye and Medical History

Patient's Name: Miss Ms. Mrs. Mr. _____ Date: _____
(Nombre) (Fecha)

Last Eye Exam: _____ **Last Physical Exam:** _____
(Útimo examen de ojos) ***(Último físico)***

Have you ever worn (please mark) ☐ Glasses (anteojos) ☐ Contacts (contactos) Brand:_____
(¿Ud. usa anteojos o contactos? ¿Cuantos años tienen los anteojos) _____

How old are your current glasses? _____**When do you wear them?**_____
(¿Cuando Ud. usa su anteojos?) _____

Any problems with your contacts or glasses? Sleep in contacts *(¿Tiene Ud. problemas con su anteojos/vista?)*

_____

Do you experience any of the following symptoms? *(Marque su síntomas)*

☐ Blurry vision (Borrosa)
☐ Burning (Ardiente)
☐ Double Vision (Doble)
☐ Eyestrain (Vista Cansada)
☐ Eye Irritation (Irritacion)
☐ Flashes (Luces)
☐ Floaters (Flotadores)
☐ Glare (Reflejo)
☐ Headache (Dolor de cabeza)
☐ Itchy (Cómezon)
☐ Light Sensitivity (Sensibilidad a la luz)
☐ Pain (Dolor)
☐ Tearing/Watery (Llorosos)

Please list all medications. *¿Qué medicamentos está tomando?*_____

_____

Allergies to any medications? *(¿Tiene Ud. alergia a medicamentos?)* _____

Do you or any of your relatives have any of the following? Please circle.
(Tiene Ud. or algunos de su familiares tiene?) Marque

• Glaucoma (Glaucoma)	Self	Family	Diabetes (Diabetes)	Self	Family
Cataracts (Cataractas)	Self	Family	High Blood Pressure	Self	Family
Macular Degeneration	Self	Family	High Cholesterol	Self	Family
Crossed Eyes (Strabismus)	Self	Family	Heart Problem (Corazón)	Self	Family
Retinal Problems (Retina)	Self	Family	Lung problems (Pulmón)	Self	Family
Ocular allergies (Alergia)	Self	Family	Liver/kidney (Hígado/Riñón)	Self	Family
Migraine (Migraña)	Self	Family	Thyroid (Tiroides)	Self	Family
Blindness (Ceguera)	Self	Family	Cancer/ Others_____	Self	Family

Do you smoke?*¿Fuma?* ☐ Never ☐ Former ☐ Current **Do you drink alcohol? *¿Bebes?*** ☐ Social ☐Yes ☐No

Lifestyle
Do you…? *¿Participa Ud…?(Marque)*
Use a computer? □ Yes □ No Hrs/day ___
Use smartphone/tablet □ Yes □ No Hrs/day ___
Drive □ Yes □ No Hrs/day ___
Drive at night □ Yes □ No Hrs/day ___
Watch TV □ Yes □ No Hrs/day ___
Play sports □ Yes □ No Hrs/day ___
Spend time in sun □ Yes □ No Hrs/day ___

Are you interested in the followings: (check)
¿Está Ud. interesado? (Marque)
□ Contact Lenses (Lentes de contactos)
□ Glasses for computer/ hobbies (Lentes para la computadora)
□ Sunglasses (Lentes del sol)
□ Safety Glasses (Lentes de seguridad)
□ Sports Glasses (Lentes de deportes)
□ Anti-glare, anti-reflection (Anti reflejante)
□ LASIK