WELCOME TO DUBLIN RANCH OPTOMETRY

PATIENT INFORMATION

Patient Name: (Ms.,Mrs.,Mr., Dr.) ____ Date:________________________

Home Address:____ City:______________________ Zip:_______________

Phone: H:( )______________________ W:( )____________________ Cell:( )______________________

E-mail Address:_____________________________ Social Security:_______________________

Date of Birth:______/______/_______ Age:_______ Gender: M / F Ethnicity:___________________________

Occupation:______________________________________ Employer:____

How did you hear about our office:

□ *Referred By:*__________________________________ □ *Insurance* □ *Other*__________________________________

PERSON RESPONSIBLE FOR ACCOUNT (Please skip if the patient is the responsible party)

Name:____ Phone Number:( )_____________________________

Social Security Number:_________________________________ Date of Birth:_____/_____/_____ Relation:_________

Home Address:____ City:______________________ Zip:_______________

INSURANCE

Name of **Vision Insurance**:______________________________

Name of **Medical Insurance**:_____________________________ Type: □HMO □PPO □ _________

EMERGENCY CONTACT

Name:______________________________ Phone Number:( )________________________________

OCULAR HISTORY

Date of Last Eye Examination:__________________ Office:____

Do you wear glasses? □ Yes □ No If yes, how old is your current pair of glasses?________

Do you wear contact lenses? □ Yes □ No *Type:* □Soft □Hard *Replacement:*______________

*Brand:*__________________________ *Care System:*_______________

Have you had any □ eye injuries or □ surgeries? Describe:______________________________________

How many hours a day do you use a computer? _____hrs How far is your computer monitor from your eyes? _____in

MEDICAL HISTORY

List any medications you take (include oral contraceptives, over-the-counter medications, home remedies, vitamins)

____

____

Do you have allergies to medications? □ Yes □ No Please list____

List all major injuries, surgeries and /or hospitalizations you have had____

____

Female patients: Are you □ pregnant or □ nursing?

SOCIAL HISTORY (This information is kept strictly confidential)

Do you drink alcohol? □ Yes □ No If yes, usage □ Mild □ Moderate □ Heavy

Do you use tobacco products? □ Yes □ No If yes, usage □ Mild □ Moderate □ Heavy

Do you use controlled substances? □ Yes □ No If yes, usage □ Mild □ Moderate □ Heavy

REVIEW OF SYSTEMS Do you or any family members currently or have ever had any problems in the following areas?

Allergic/Immunologic	Self	Family
Environmental allergy	☐	___________
HIV	☐	___________
Lupus	☐	___________
Other:___________	☐	___________
Cardiovascular/Vascular		
High blood pressure	☐	___________
High cholesterol	☐	___________
Stroke	☐	___________
Other:___________	☐	___________
Constitutional		
Fever, weight loss/gain	☐	___________
Other:___________	☐	___________
Ear, Nose, Mouth, Throat		
Sinus congestion	☐	___________
Chronic cough	☐	___________
Other:___________	☐	___________
Endocrine		
Diabetes	☐	___________
Hormonal dysfunction	☐	___________
Thyroid dysfunction	☐	___________
Other:___________	☐	___________
Eyes		
Blindness	☐	___________
Cataracts	☐	___________
Crossed eye/lazy eye	☐	___________
Double vision	☐	___________
Glaucoma	☐	___________
Macular degeneration	☐	___________
Retinal disease	☐	___________
Other:___________	☐	___________

Reviewed by: Dr._____ Date:_______________

Gastrointestinal	Self	Family
Irritable bowel syndrome	☐	___________
Crohn's Disease	☐	___________
Other:___________	☐	___________
Genitourinary		
Kidney dysfunction	☐	___________
Sexually transmitted disease	☐	___________
Other:___________	☐	___________
Hematologic/Lymphatic		
Anemia	☐	___________
Bleeding disorder	☐	___________
Other:___________	☐	___________
Integumentary (skin)		
Eczema	☐	___________
Rosacea	☐	___________
Other:___________	☐	___________
Musculoskeletal		
Fibromyalgia	☐	___________
Rheumatoid arthritis	☐	___________
Other:___________	☐	___________
Neurological		
Migraines	☐	___________
Multiple sclerosis	☐	___________
Seizures	☐	___________
Other:___________	☐	___________
Psychiatric		
Anxiety	☐	___________
Depression	☐	___________
Other:___________	☐	___________
Respiratory		
Asthma	☐	___________
Emphysema	☐	___________
Other:___________	☐	___________

RESPONSIBILITY STATEMENT: Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for you bill.

FINANCIAL RESPONSIBILITY: By signing this statement you agree to be financially responsible for all charges.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize any holder of medical information about me to release to Dublin Ranch Optometry any information needed to determine insurance benefits or process insurance claims. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

NOTICE OF PRIVACY PRACTICES: I have read and understand the "Notice of Privacy Practices" from Dublin Ranch Optometry.

CONSENT TO DILATE: I have been informed of the benefits and side effects of a dilated eye examination. I understand that a dilation provides important information of my eye health so that my Doctor can better diagnose and treat any eye conditions that may be present.

Please check one: **_____ I consent to have my eyes dilated today** **_____ I decline to have my eyes dilated today**

Patient's/Guardian's Signature:____ **Date:** _______/________/________