WELCOME TO OUR OFFICE!

NAME:___________________________DOB____________Age: ____ SS#______________ Occupation_________________

Address:_______________________________________City_________________________State________Zip______________

Phone#________________________________Work#____________________________Cell#____________________________

Emergency Contact:____Phone #_______________________

Last Eye Exam _________Last Medical Exam___________Name of Medical Doctor _______________Phone#______________

Vision Insurance:____________Primary Subcriber:__________________SS#____________DOB_________Relationship______

Medical Insurance: please circle one: Kaiser BCBS Principal United Health Care Aetna Cigna Pacific Care

Other:____

FAMILY HEALTH HISTORY

Please check any conditions that apply to your immediate family members:

- ☐Blindness
- ☐Cataract
- ☐Crossed Eyes
- ☐Diabetes
- ☐Glaucoma
- ☐Macular Degeneration
- ☐Retinal Detachment
- ☐Cancer
- ☐Heart Disease
- ☐High Blood Pressure
- ☐Lupus
- ☐Arthritis
- ☐Thyroid Disease
- ☐Other:_________________

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PATIENT'S OCULAR/ MEDICAL HISTORY

Do you have any allergies to medications? _____Yes ____No. If yes, please list_______________________________________

List all the medications you are currently taking:____

List all the major injuries, surgeries, and /or hospitalization you have had:____

Are you pregnant and/or nursing? ____ Yes ____No

Do you wear glasses? ____ Yes ____No If yes, How old is your current pair of glasses? ________________

Do you wear contact lenses? ____ Yes ____No Type of contact lenses: ___________________________________

Please check any conditions that you have or have had in the past:

- ☐Blurred Vision
- ☐Loss of Vision
- ☐Double Vision
- ☐Crossed Eyes
- ☐Lazy Eye
- ☐Eye Surgery
- ☐Cataract
- ☐Retinal Detachment
- ☐Flashes/Floaters
- ☐Macular Degeneration
- ☐Glaucoma
- ☐Pain
- ☐Excessive Tearing
- ☐Dryness
- ☐Itching/Burning
- ☐Mucus Discharge
- ☐Eye Injuries
- ☐Eye Infection/Redness
- ☐Diabetes
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐Stroke
- ☐Headache
- ☐Migraine
- ☐Seizure
- ☐Thyroid
- ☐Cancer
- ☐Arthritis
- ☐Anemia
- ☐Anxiety/Depression
- ☐Sinus Congestion
- ☐Asthma
- ☐Emphysema
- ☐Other:_______________

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Do you use tobacco products? ____YES ____NO (If yes) type/ amount/ how long:_______________________________

Do you drink alcohol? ____YES ____NO (If yes) type/ amount/ how long:_______________________________

Do you use recreational drugs? ____YES ____NO (If yes) type/ amount/ how long:_______________________________

Have you ever been exposed to or infected with: _____ Gonorrhea ______Hepatitis ______HIV ______Syphilis

HOW DID YOU HEAR ABOUT US:____

NOTICE OF PRIVACY

The Health Insurance Portability and Accountability Act (**HIPPA**) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at **DR. STACY VO OPTOMETRY**, we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. **This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls.**

By signing below, I acknowledge that I have read/receive the copy of the Notice of Privacy Practices for review.

_______________________________________ ____________________________

(Patient's Signature or Legal Representative) (Date)

PLEASE TURN OVER AND COMPLETE SIDE TWO

DILATION CONSENT

Dilation is the enlargement of the pupil diameter, which allows the doctor to observe the internal eye more completely to rule out maladies such as glaucoma, retinal detachment, cataracts, eye tumors, and other sight or life threatening conditions. We always prefer to have our patients driven after their dilation, as the eye drops cause blurred vision and extra light sensitivity on sunny days for up to 6 hours. Disposable shaded lenses might be provided to reduce light sensitivity.

______YES, I give permission to the doctor to perform dilation today.

______ NO, I choose not to have dilation done. I understand that an exam of the retina through a dilated pupil is necessary to detect conditions that would otherwise be unobservable. These conditions, if undetected, may lead to partial of total vision loss.

______I prefer to have dilation done at a later date.

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I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such eye care to third parties payers and /or health practitioners. I authorize and request my insurance company including coordinate of benefit from medical insurance to pay directly to **DR. STACY VO OD, INC.** I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductible and fees not paid by my insurance carrier will be my responsibility. I also understand that there will be no refunds for rendered professional medical services related to eye exams or contact lens fitting or evaluations.

_______________________________________ _____________________________

(Patient’s Signature or Legal Representative) (Date)

For Established Patient

Please record any changes from your health history since the last visit. Sign and date next to the updates. Thank you.

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