Mt. View EyeCare

Chart No. _____

PATIENT GENERAL INFORMATION:

Last Name: _____ First Name: _____ MI: ____ Title: _____

Nickname: _____ Date of Birth: _____ ☐ Male ☐ Female Social Security #: _____

Address: _____ Apt.# _____

City: _____ State: _____ ZIP: _____ Home Phone: _____

Work Phone: _____ Cell: _____

Email: _____ Referred by: _____

Marital Status: ☐ Single ☐ Divorced ☐ Married Spouse's Name: _____ Patient? ☐ Yes ☐No

Your Employer: _____ Your Occupation: _____

Emergency Contact: _____ Phone: _____ Cell: _____

Relationship: _____

☐ **I understand and agree that regardless of any insurance, I am ultimately responsible for the balance of my account for any services rendered.** I have read all the information on this form and I have completed the above questions. I certify that this information is true and correct to the best of my knowledge. Further, I will notify you of any changes in my health status or above information.

☐ **Insurance Patients Only**: I hereby authorize my insurance benefits to be paid to Mt. View EyeCare Center for any services furnished to me. I authorize any holder of medical data about me to release information to Medicare, Medicaid or other insurance companies and their agents any information needed to determine these benefits or benefits payable for related services. I agree that I am financially responsible for any non-covered services.

Payment: I will be paying today by: ☐ **Cash** ☐ **Check** ☐ **Credit Card** ☐ **Insurance**

_____ _____ Signature of Patient/Parent (Date)	**Notice of Privacy Practices:** **(Please Mark One)** ☐ I was offered and read a copy of the privacy policy. ☐ I have read, signed and requested a copy be included in my file(s). ☐ I have declined to read or sign the privacy policy.

Do you plan on purchasing new eyewear/contacts today? ☐ Yes ☐ No ☐ If prescription changed.

REASON FOR TODAY'S VISIT (or problems you've noticed recently):

☐ Eye Examination	☐ Eyes that Burn.	☐ Visual Fields Study.
☐ Eye Exam for Glasses	☐ Eyes that Itch.	☐ Photographs, Front or Back of the Eye
☐ Eye Exam for Contact Lenses	☐ Eyes that are Red.	☐ Safety Glasses
☐ Eye Examination for Diabetes	☐ Eyes that are Painful.	☐ Sports/Diving Eye Protection
☐ Eye Examination for Glaucoma	☐ Contact Lens Problems.	☐ Recheck my Refraction
☐ Eye Examination for Dry Eyes	☐ Loss of Side Vision.	☐ Other _____
☐ Eye Examination for Laser Vision	☐ Loss of Upper Field of Vision.	_____

Mt. View EyeCare

MEDICAL HISTORY

Chart No. _____

GLASSES

Do you currently wear glasses	☐ Yes	☐ No
Are you satisfied with your glasses?	☐ Yes	☐ No
Do you wear prescription sunglasses?	☐ Yes	☐ No
Do you wear safety glasses?	☐ Yes	☐ No

Any Problems? _____

_____

_____

CONTACT LENSES

Do you ever wear contact lenses?	☐ Yes	☐ No
Have you worn contact lenses in past?	☐ Yes	☐ No
Are you interested in wearing contacts?	☐ Yes	☐ No

LASER VISION CORRECTION

Have you had LASIK or PRK surgery?	☐ Yes	☐ No
Have you had RK surgery in the past?	☐ Yes	☐ No
Interested in learning more about LASIK?	☐ Yes	☐ No

EYE HISTORY	Self	Mother	Father	EYE HISTORY	Self	Mother	Father
Amblyopia (Lazy eye)	☐	☐	☐	Pink or Red Eye-Conjunctivitis	☐	☐	☐
Cataracts	☐	☐	☐	Laser Surgery	☐	☐	☐
Color Blindness	☐	☐	☐	Retinal Detachment	☐	☐	☐
Glaucoma	☐	☐	☐	Spots or Floaters	☐	☐	☐
Macular Degeneration	☐	☐	☐	Strabismus-Eye Turns In/Out	☐	☐	☐
Flashes of Light	☐	☐	☐	Other:	☐	☐	☐

MEDICAL HISTORY	Self	Mother	Father	MEDICAL HISTORY	Self	Mother	Father
Acid Reflux Disorder (GERD)	☐	☐	☐	Heart Disease	☐	☐	☐
Acne Rosacea	☐	☐	☐	High Blood Pressure	☐	☐	☐
Anxiety	☐	☐	☐	High Cholesterol	☐	☐	☐
Arthritis	☐	☐	☐	Kidney Disease	☐	☐	☐
Asthma	☐	☐	☐	Lupus	☐	☐	☐
Cancer	☐	☐	☐	Sarcoidosis	☐	☐	☐
COPD	☐	☐	☐	Sleep Disorders	☐	☐	☐
Depression	☐	☐	☐	Stroke	☐	☐	☐
Diabetes-Taking Insulin	☐	☐	☐	Thyroid, Low or High	☐	☐	☐
Diabetes-Taking Tablets	☐	☐	☐	Other-Please Enter Condition			
Herpes (Any Form)	☐	☐	☐		☐	☐	☐
Headaches	☐	☐	☐		☐	☐	☐

Female Patients: Are you pregnant or post partum? ☐ Yes ☐ No If No, are you nursing? ☐ Yes ☐ No

Do you smoke or chew? ☐ Yes ☐ No

Medications you take – Include all Prescriptions & Over the Counter (OTC) drugs:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

ALLERGIES

Do you have allergies to prescription drugs? ☐ Yes ☐ No

If yes, to what?: _____

_____

Other allergies (foods, pollens, etc.:) _____

_____

EYE SURGERY

Have you ever had Eye Surgery? ☐ Yes ☐ No

If so, please specify: _____

_____

_____

Submit

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