Dr. Charters & Dr. Nishijima, Optometrists

Thank you for choosing our office for your vision care. In order to provide you with the best care possible, we ask that you answer the questions below. If you prefer, we will be happy to sit down with you to help you complete this form. We are here to assist you!

Name: ______________________________ __________________________ ______ Date: ______________
(last) (first) (m.i.)

Social Security #: ____________________ Sex: ☐ M ☐ F Date of Birth: ______________ Age:_____

Address: _____________________________________ City: ______________ State: ____ Zip: ______________

Phone (home): (___) ______________ Phone (work): (___) ______________ Occupation: __________________

Cell phone: (___) ______________

MEDICAL INFORMATION

Many health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the following information so that your doctor can provide you with the most thorough evaluation of your eye health. Have you had any ongoing problems with any of the following systems? Please check (✓) all that apply.

- ☐ gastrointestinal
- ☐ ears/nose/throat
- ☐ cardiovascular/heart disease
- ☐ respiratory/breathing
- ☐ high blood pressure
- ☐ nervous system
- ☐ urinary tract
- ☐ muscles/bones
- ☐ integument/skin
- ☐ cancer
- ☐ endocrine/glands
- ☐ blood/lymph
- ☐ allergic/immunologic
- ☐ headaches
- ☐ psychiatric/psychological

☐ diabetes (for how long: ___________) ☐ type 1 ☐ type 2

Please explain any of the above: ____

____

____

Other health problems: ____

Are you currently taking medication (including non-prescription and herbal remedies)? ☐Y ☐ N If yes, please list: _

____

____

Do you use cigarettes/tobacco? ☐Y ☐ N Do you use alcohol? ☐Y ☐ N Do you use recreational drugs? ☐Y ☐N

Name of your primary care doctor: ____ Date of last visit: _____________

FAMILY EYE & MEDICAL HISTORY

Please check (✓) any conditions that have occurred in your immediate family:

- ☐ glaucoma relation: __________
- ☐ macular degeneration relation: __________
- ☐ retinal detachment relation: __________
- ☐ cataracts relation: __________
- ☐ diabetes relation: __________
- ☐ high blood pressure relation: __________

(PLEASE COMPLETE SECOND PAGE)

PATIENT'S EYE HISTORY

Date of last eye exam: ____________ By whom? ____ Dilated? ☐Y ☐N

Do you wear glasses? ☐Y ☐N Do you wear contact lenses? ☐Y ☐N If yes: ☐ soft ☐ gas permeable/hard ☐ disposable

Please check any of the following conditions you have had:

☐ glaucoma ☐ retinal detachment ☐ dry eyes ☐ cataracts ☐ macular degeneration

Do you have any other eye conditions or problems? If so, please describe: ____

____

Have you had a serious eye injury or eye surgery? If so, please describe: ____

____ Date(s) of above: ____________________________

Are you using any eye drops (prescription or over-the-counter)? Please list: ______________________________________

Please describe any problems with your eyes for which you are seeking treatment today: ____________________________

____

Check all that apply: ☐ itchy eyes ☐ stinging/burning ☐ flashes/floaters ☐ eyestrain/eye fatigue ☐ blurry vision ☐ red eyes

In order to assist us in processing your insurance claim and to allow for communication with your other health care providers, please read and complete the following.

INSURANCE AUTHORIZATION:

IF YOUR INSURANCE IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:

POLICY HOLDERS NAME: ________________________ POLICY HOLDERS DATE OF BIRTH: ___/___/_______

RELATIONSHIP TO YOU: ______________________________ INSURANCE I.D. NO: ________________________

I authorize this office to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to this office for any services furnished me at this office. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine the benefits payable for related services for myself and/or my dependents.

Patient/guardian signature________________________________

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT:
We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your records to others unless you direct us to do so unless legal authorities compel us to so.

FOR DOCTORS USE ONLY:
This form was reviewed by: _________________________ _______________

Date:

_________________________ _______________

_________________________ _______________

O.L. 1/25/09