Welcome to *California Optical*

Date _____

Last Name _____ First Name _____ MI_____
Address _____City_____ Zip _____
Email_____DOB_____Gender: M/F
Phone (C) _____ (H) _____
Occupation _____ Last Eye Exam_____
If minor, Parent/Guardian name_____
Vision Plan_____Name of Insured_____
DOB of Insured_____ID#orSS#of Insured_____

PERSONAL AND FAMILY MEDICAL AND EYE HISTORY

Do you or any member of your family have, or have had any problems in the following areas?
Circle Y (Yes) or N (No)

	ME	FAMILY		ME	FAMILY
Diabetes	Y/N	Y/N	Bleeding problems	Y/N	Y/N
High blood pressure	Y/N	Y/N	Hepatitis	Y/N	Y/N
Heart problems	Y/N	Y/N	HIV or AIDS	Y/N	Y/N
Cholesterol	Y/N	Y/N	Allergies	Y/N	Y/N
Asthma	Y/N	Y/N	Lazy Eye	Y/N	Y/N
Arthritis	Y/N	Y/N	Glaucoma	Y/N	Y/N
Thyroid	Y/N	Y/N	Macular Degeneration	Y/N	Y/N
Cataracts	Y/N	Y/N	Do you smoke?	Y/N	Y/N
History of substance abuse?	Y/N	Y/N	History of alcohol abuse?	Y/N	Y/N
Female patients only:			Are you pregnant?	Y/N	

Please list all medication(s) that you are currently taking: _____
_____
Please list allergies to prescription and non-prescription medications: _____
_____

PERSONAL EYE HISTORY

Reason for today's exam:_____
Do you currently wear glasses? Y/N Do you currently wear contacts? Y/N
Do you currently use eye drops? Y/N If yes, what kind_____
If blurred vision, at what distance(s)? Far / Close / Far and Close
Have you had any previous eye surgery? Y/N
If yes, date and type: _____
Have you had any eye injuries? Y/N
If yes, date and type: _____
Previously had eyes dilated? Y/N
If yes, any significance side effects? _____

ATTESTATION

Dilated exam - I understand that a condition with the potential for partial or total loss of vision may exist and without dilation it may go undetected. Being advised of the above,
I **agree/decline** to have my eye dilated. **I assume the risks if my refusal.** _____**Initials**
Additional $35 fee for dilation (except VSP patients)

Glaucoma Eye Pressure Test - I understand that if I have glaucoma and a pressure test is not performed, the disease may go undetected with the potential for a partial or total loss of vision. Being advised of the above, I **agree/decline** to have my eyes tested for glaucoma.
I assume the risks if my refusal. _____**Initials**

I authorize payment for my vision benefits directly to the Doctor. I agree that if my employer, insurance carrier or plan sponsor denies payment of all or any portion of my claim, I will be financially responsible for all outstanding charges. Authorization at time of service does not guarantee payment.

Signature X _____ **(Parent/Guardian if minor)**

California Optical

1525 W. 13th Street, Suite A
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NOTICE OF PRIVACY PRACTICES

We understand the importance of the privacy of your medical information and are committed to maintaining its confidentiality. We are required by law to maintain the privacy of protected health information and provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This is to inform you of how your information may be used and disclosed and how you can get access to your information.

We keep a medical record of the care and treatment you have received. Your records are used in the following three ways:

1. For your reference in providing you continuous quality health care.
2. Provided to other health care providers in order that they may provide you quality medical care.
3. Provided to medical insurance companies to bill for payment of services.

You have the right to request that your medical record be released to yourself or another healthcare provider.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIVES

I, the undersigned, acknowledge that I have received a copy of this medical NOTICE OF PRIVACY PRACTICES

Print Name: _____

Signature: _____

Date: _____

If not signed by the patient, put check mark next to the applicable relationship below:

_____ Parent or legal guardian