Joel L. Cook, O.D.
Kevin Reeder, O.D.
Barbara Bytomski, O.D.
Earl Sandler, O.D.

Welcome to Our Office

So that we can help you best, please fill out both pages legibly and completely.

Full Name ____ Today's date ____

Name you go by (if different) ______________________________ Date of birth ________________________ Sex: M F

Home address ____ Social security number _____________________________________

City ____________________ State _______ Zip _______________ Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home phone ___(_________)_______________________________ Employer (or School) _____________________________________

Cell phone ___(_________)_______________________________ Occupation (or Grade) ____________________________________

Em ail address ____
(for exam information, statements, product info, notifications, etc)

Who is responsible for paying your account balance?
__Yourself
__Other Name & Relationship: ______________________

Medical Insurance ____ **Name of Primary Care Physician** ____________________________

Is it an ☐ HMO (Health Maintenance Organization, e.g. Kaiser, Sharp, Scripps) ☐ PPO (Preferred Provider Organization, e.g. Blue Cross)

Are you a member of an eye care plan? ☐ Yes ☐ No If yes, please circle your plan below:
Vision Service Plan (VSP) Medical Eye Services (MES) EyeMed / ECPA Superior Vision Other _______________________

How did you first hear about us? ☐ Eye care plan directory ☐ Newspaper or TV ☐ Yellow Pages ☐ Internet
☐ Family, friend, or co worker ☐ Doctor referral **If another person recommended us, who** : _________________________________

Reason(s) for your visit today? ☐ Routine check up ☐ Contact lens evaluation ☐ Ocular health evaluation
☐ New glasses ☐ New contact Lenses ☐ Low vision evaluation ☐ Corneal Refractive Therapy (CRT) evaluation
☐ Vision Therapy ☐ School referral ☐ Failed DMV eye test ☐ Laser Vision Correction evaluation
☐ iZON™ high definition glasses ☐ Other ____

When was your last comprehensive eye examination? ☐ Never ☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5+ years

Do you wear glasses? ☐ Yes ☐ No **If yes, do you wear them** ☐ Full time ☐ Part time ☐ Seldom

For what purpose were they prescribed? ☐ General use ☐ Distance Only ☐ Near Only ☐ Computer Use ☐ Occupational ☐ Safety ☐ Sport

Describe your computer use: ☐ Extensive (5+ hrs/day) ☐ Moderate (1 4 hrs/day) ☐ Low (Less than 1 hr/day) ☐ Seldom ☐ Never

Chief complaint(s): ☐ None ☐ Distance Blur ☐ Near Blur ☐ Intermediate Blur ☐ Computer blur & eye fatigue
☐ Trouble reading ☐ Headaches ☐ Eyestrain ☐ Eyes burn ☐ Eyes water ☐ Pressure around eyes
☐ Eyes feel sandy/gritty ☐ Eye pain ☐ Eyes red ☐ Floaters / Flashes ☐ Double vision ☐ Decreased side vision
☐ Light sensitivity ☐ Eyes itch ☐ Other (describe) ____

Eye surgeries: ☐ None ☐ LASIK ☐ PRK ☐ RK ☐ Intacs™ ☐ Cataract ☐ Retinal ☐ Glaucoma ☐ Eyelid ☐ Other __________________

Have you had a serious eye injury? ☐ Yes ☐ No **If yes, please describe** ____

Any other eye problems? ☐ Yes ☐ No **If yes, please describe** ____

Which statement applies to you? ☐ I've never worn contacts (skip rest of this section) ☐ I wear contacts daily
☐ I wear contacts occasionally ☐ I used to wear contacts

If you wear contacts, do you sleep with them regularly? ☐ Yes ☐ No
If yes, how many nights in a row will you wear them without removal? ____

Are your contacts ☐ Soft ☐ Rigid ☐ Disposable ☐ Non disposable
☐ Monovision ☐ Bifocal / Multifocal ☐ For astigmatism ☐ Other ________________________________

If *soft disposable*, which brand and lens power are you wearing (if known) ____

How old is the pair you are currently wearing? ______________________ **How frequently do you replace a pair?** ______________________

Please complete the second page . . .

Copyright © 2006 Carmel Mountain Vision Care. All rights reserved.

Welcome to Our Office, Page 2

Family Medical History			
Blindness or Visual Disability	Y	N	Unsure
Cataracts	Y	N	Unsure
Diabetes	Y	N	Unsure
Glaucoma	Y	N	Unsure
High Blood Pressure	Y	N	Unsure
Macular Degeneration	Y	N	Unsure
Other disease (please specify) ____			

Personal Medical History

Since many general medical conditions can affect the eye, we need to know of any medicines you take and any medical conditions you have

Do you take any prescription or non prescription medicines regularly? Y N (If yes, please list all below or provide as attachment)

____ ____

____ ____

Medication allergies: ☐ None known ☐ Penicillin ☐ Sulfa drugs ☐ Codeine ☐ Other ___________________________

Do you have any conditions of the following medical systems?	**(Please circle)**		**If yes, please explain**
Ear / nose / throat (e.g. soreness, hearing loss)	Y	N	____
General constitution (e.g. fever, weight gain/loss, malaise)	Y	N	____
Blood (e.g. anemia, bleeding disorders)	Y	N	____
Genitourinary (e.g. kidney failure, prostate/ovarian cancer)	Y	N	____
Muscle / joints (e.g. weakness, arthritis)	Y	N	____
Endocrine (e.g. diabetes, hypo or hypert hyroid)	Y	N	____
Skin (e.g. rash, dryness)	Y	N	____
Cardiovascular (e.g. high blood pressure, stroke, heart)	Y	N	____
Neurologic (e.g. tingling, numbness, headaches)	Y	N	____
Respiratory (e.g. shortness of breath, asthma)	Y	N	____
Psychiatric (e.g. depression, memory loss)	Y	N	____
Gastrointestinal (e.g. stomach pain, diarrhea, constipation)	Y	N	____
Allergic / Immunologic (e.g. hayfever, HIV)	Y	N	____

So that we can get to know you better, what hobbies, sports, or other activities do you enjoy?

PRIVACY PRACTICES ACKNOWLEDGEMENT AND 3RD PARTY PAYMENT AUTHORIZATION

I acknowledge that I have received a copy of Carmel Mountain Vision Care's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, www.CarmelMountainVisionCare.com. Additionally, I authorize the payment of any eye care benefits or medical insurance to my Doctor of Optometry. I understand that I may have copa yments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred.

Patient name ___________________________ Signature of patient (or parent/guardian for minors) ________________________________

Thank you!

Copyright © 2006 Carmel Mountain Vision Care. All rights reserved.