3101-C Crow Canyon Pl., San Ramon, CA 94583

# 20/20 Optometry

115 West 25th Ave., San Mateo, CA 94403

Today's Date: _____ (Month / Day / Year)

Date of last eye exam _____ (Month / Day / Year)

**Patient Information** (Please Print):

Driver License Number: _____

Patient's Name _____ (Last) , _____ (First) ____ (M.I.)

Date of Birth: _____ (Month / Day / Year)

Home Address _____

Phone (home) _____

City, State, Zip _____

Phone (cell) _____

Patient's Social Security Number _____

Email address _____

Employer _____

Phone (work) _____

**Medical Insurance** _____

**We will need to make a copy of your card.**

Insured's Name _____ (Last) , _____ (First)

Insured's social security number _____

Insured's Date of Birth _____ (Month / Day / Year)

**Vision Insurance** _____

**We will need to make a copy of your card.**

Insured's Name _____ (Last) , _____ (First)

Insured's social security number _____

How did you hear about our office: _____

Who referred you _____

Family Information: Spouse _____ Children _____ Patients in our office? Y / N

Are you interested in learning about Children and Infant Vision? Y / N

Are you interested in Laser Vision Correction? Y / N

**Family Medical History** (Please circle yes or no, if not answer it will be assumed no.)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Arthritis | No | Yes | Maternal | Paternal | Glaucoma | No | Yes | Maternal | Paternal |
| Cancer | No | Yes | Maternal | Paternal | Cataracts | No | Yes | Maternal | Paternal |
| Diabetes | No | Yes | Maternal | Paternal | Eye Disease | No | Yes | _____ | |
| High Blood Pressure | No | Yes | Maternal | Paternal | Eye Surgery | No | Yes | _____ | |
| Retinal Detachment | No | Yes | Maternal | Paternal | Other | No | Yes | _____ | |
| Macular Degeneration | No | Yes | Maternal | Paternal | Other | No | Yes | _____ | |

**Personal Medical History** (Please circle yes or no, if not answer it will be assumed no.)

Name of Family Doctor _____

Date of last visit _____

Do you have any problems with any of these systems?

| | | | | | | Current Medications (name/dosage/year started) | |
|---|---|---|---|---|---|---|---|
| Allergic/Immunologic | No | Yes | Glaucoma | No | Yes | Antihistamines | _____ |
| Blood/Lymph | No | Yes | Cataracts | No | Yes | Diuretics | _____ |
| Cardiovascular | No | Yes | Dry Eyes | No | Yes | Blood Pressure | _____ |
| Cancer | No | Yes | Macular Degeneration | No | Yes | Diabetes | _____ |
| Diabetes | No | Yes | Retinal Detachment | No | Yes | Cholesterol | _____ |
| Endocrine | No | Yes | Eye Injury | No | Yes | Birth Control | _____ |
| High Blood Pressure | No | Yes | Eye Surgery | No | Yes | Other | _____ |
| Respiratory | No | Yes | Allergies to Medication | No | Yes | _____ | |

If YES to any above, please explain _____

List any complaints about your eyes, glasses, or contacts: _____

| | | | | | |
|---|---|---|---|---|---|
| Do you have more than one pair of glasses? | No | Yes | Do you work on the computer at work? | No | Yes |
| Would you like information on lighter, thinner lenses? | No | Yes | Are there times you'd rather not wear glasses? | No | Yes |
| Do you play sports, swim, or enjoy outdoor activities? | No | Yes | Are you happy with your current contacts? | No | Yes |
| Do you experience any headaches or eyestrain? | No | Yes | Do you see floaters or flashes of light? | No | Yes |
| Are your eyes dry and itchy during the day? | No | Yes | Are you sensitive to light and the sun? | No | Yes |

By signing below, I acknowledge that I have read and was given a copy of 20/20 Optometry Notice of Privacy Practices that is valid for 6 years. I certify that I have read and understood the above information and the questions have been answered accurately. I realize that inaccurate answers may affect my health. I understand that my insurance information may be obtained or submitted electronically or by fax if order to receive authorization or payment. I authorize the doctor to release any records including the diagnosis and treatment rendered to me or my child. I request my insurance company pay directly to the above eye doctor or group. I understand that my insurance may pay less than the stated amount. I will be responsible for the balance of all services and products rendered to myself and/or my family. If in the event any collections or disputes, I agree to pay for all court costs and late charges.

Signature of Patient or guardian: _____