Welcome to .....

El Paso Optical

PATIENT INFORMATION FORM

Last Name _____ **First Name** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Sex (circle) **Male Female** **Date of Birth** _____ **Age** _____

Soc. Sec. # _____ **Marital Status:** (circle) **Married Single Divorced Widowed Other**

Race: (circle) **Hispanic African American/Black American Indian/Alaskan White Asian Native Hawaiian/Pacific Islander Decline to Specify Other**

Preferred Language: _____

Employer _____ **Employment Status** (circle) **Part Time Full Time**

Occupation _____ **E-mail** _____

In an emergency, notify _____ **Relationship** _____ **Phone** _____

How did you hear about us? (circle) **Our Website Insurance List Laser Center Yelp Other**
Family/Friend _____ **Doctor's Office** _____

Bill my insurance for the exam Y / N _____ (initial) **Retinal Photo Y/N** _____ (initial) **Dilation Y/N (Except VSP)** _____ (initial)

I received/read the HIPAA Privacy Act Form _____ (initial) **I received/read the Office Policy Form** _____ (initial)

INSURANCE INFORMATION

(Sponsor's or Self Insurance Information)

Medical Insurance _____ **Policy Holder** _____ **ID #** _____

Relationship to Patient _____ **Policy Holder's DOB** _____ **Policy Holder's SS#** _____

Address _____ **City** _____ **State** ____ **Zip Code** _____
(If different from above)

Home Phone _____ **Cell Phone** _____

Employed by _____ **Occupation** _____ **Wk. Phone** _____

Please Read Carefully:

I understand that my (or my dependent's) medical records are confidential but may be reviewed by entities listed in the HIPAA Privacy form. I can remove this consent by written request to El Paso Optical. I assign El Paso Optical all insurance benefits for services rendered. I understand that I am financially responsible for ALL charges and balances left by my insurance. In the event that my insurance does not compensate El Paso Optical for services within 90 days, all balances will become my responsibility to pay. I will also be responsible for all attorney and collection agency fees. I have read the above and fully understand and acknowledge the terms and conditions stated.

_____ _____ _____
Signature of Patient or Guardian **Print Name** **Date**

Name: _____ DOB: _____ Age: _____ Occupation: _____

HEALTH HISTORY / REVIEW OF SYSTEM

EYES: Tell us about your eyes. What is your reason for this visit? Ex., glasses/contacts, loss of vision?

What is your chief complaint? (Must be answered) ☐ Near ☐ Far ☐ None ☐ Other: (If other, please explain symptoms)

_____

_____

EYE HISTORY:

Date of last eye exam _____ Name of last Eye Doctor _____

Do you wear Glasses? Y N (Or) Contact Lenses? Y N Name/Type _____

Are you interested in Contact Lenses? Y N Are you interested in LASIK? Y N

List all current or past eye diseases, injuries or eye surgeries _____

_____

FAMILY HISTORY:

Has any member of your family been diagnosed with the following? (please circle the relationship M=Mother/F=Father)

Glaucoma M F Cataracts M F Macular Degeneration M F High Cholesterol M F Diabetes M F

HEALTH HISTORY:

Primary Care Physician _____ Phone _____

DO YOU HAVE ANY OF THE FOLLOWING?

Diabetes Y N High Blood Pressure Y N High Cholesterol Y N Pregnant or Nursing Y N

List all major illnesses/surgeries in the past five (5) years: _____

_____

_____

REVIEW OF SYSTEMS: Do you have any of the following? Please note and explain in the comment section.

Cardiovascular	Y	N	Constitutional	Y	N	Ear/Nose	Y	N
Endocrine	Y	N	Immunologic	Y	N	Mouth/Throat	Y	N
Neurologic	Y	N	Psychiatric	Y	N	Muscles/Joints	Y	N
Integumentary	Y	N	Genitourinary	Y	N	Bones	Y	N
Respiratory	Y	N	Hematological	Y	N	Gastrointestinal	Y	N

Comments: _____

_____

DO YOU USE ANY OF THE FOLLOWING:

Alcohol Y N Recreational Drugs Y N

Smoke Y N

PROVIDE US WITH:

Height _____ (inches)

Weight _____ (pounds)

MEDICATIONS		ALLERGIES	
List any medications you are currently taking		List all medications that you are allergic to	List all other allergens (environmental)
NONE		NKDA	NKA