

WELCOME TO ESTRELLA EYECARE

Please fill out completely:

Today's date: ___/___/___

Patient Name: _____ Date of Birth: ___/___/___
 (Mr/Ms/Miss) Last, First MI Apt# Phone: (____) _____ Home
 Address: _____
 City: _____ ST _____ Zip _____ Phone: (____) _____ Cell
 Name of Parent: _____ DOB: _____ Last Eye Exam _____
 School attending: _____ Grade: _____
 Name of Medical Doctor: _____ Dr's Phone: (____) _____
 Vision Insurance: (Circle one): Mercy Care OTHER _____ Member ID #: _____

MEDICAL HISTORY Please answer the questions on the lines provided. If there is nothing to list, write "N/A" (non applicable).

Are you pregnant and/or nursing? No Yes N/A
 List any current health problems: _____

Do you have any allergies to medications? No Yes If yes, explain _____

List any medicines you are currently taking, including eye drops or over-the-counter medicines: _____

REVIEW OF SYSTEMS Do you or a family member currently, or have ever had any problems in the following areas? If you answered YES to any one of these questions, please explain and list the medications you take for it. If a family member has a condition, please write in next to the box their relationship to you and explain the condition.

SYSTEM	SELF No	SELF Yes	EXPLAIN/ FAMILY MEMBER	SYSTEM	SELF No	SELF Yes	EXPLAIN/ FAMILY MEMBER
EARS, NOSE, THROAT				THYROID DISEASE			
SKIN				BONES/JOINTS/MUSCLES			
MENTAL				CANCER			
ASTHMA or breathing problems				ALLERGIES			
HEART DISEASE				EYES: Blurred Vision			
HIGH BLOOD PRESSURE				EYES: Lazy or Crossed			
STOMACH OR INTESTINAL				EYES: Disease or Surgery			
GENITAL or URINARY				EYES: Injury			
DIABETES				EYES: OTHER			
OTHER:							

Patient Consent: The above questions were answered to the best of my knowledge. I authorize the release of information pertaining to this vision examination to my insurance carrier(s), my physician(s), concerned eye care professionals, or in the case of a child, educational specialists (teachers, school nurse, etc.) under the following conditions: 1) detailed description of the information being released, 2) to whom may the information be released, 3) the purpose for the release, 4) expiration date or event. In the case of a minor, I (the parent/legal guardian) authorize Estrella EyeCare to treat my child for any eye-related care, if I am not present. I agree to pay for any and all services/products at the time of this eye exam if I do not have insurance or if it is not valid per prior authorization, or if insurance is valid I will pay the difference the insurance pays. : HIPPA I have also been provided with the "Notice of Privacy Practice" (see clipboard)

Patient (or parent/legal guardian): (signature) _____ Date: _____

Doctor's initials: _____ Date: _____

Payment is required at the time of services rendered.