

# WELCOME BACK TO ESTRELLA EYECARE

Today's date: \_\_\_/\_\_\_/\_\_\_

(Mr / Mrs / Miss / Ms / Dr)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Last, First MI

Address: \_\_\_\_\_ Apt# \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Home

City: \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Work

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Cell

Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

(EMAIL is used to communicate with you for appointment confirmations, updates, etc)

NOTE: All Patient information is kept strictly confidential. Your information is NEVER shared

Marital Status: Single  Married  Widowed  Child  Other  \_\_\_\_\_

Spouse's name: \_\_\_\_\_ If child, name of parent \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

**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: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Dr's Phone: (\_\_\_\_) \_\_\_\_\_

**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.*

SYSTEM	SELF No	SELF Yes	EXPLAIN	SYSTEM	SELF No	SELF Yes	EXPLAIN
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:							

Doctor's initials: \_\_\_\_\_ Date: \_\_\_\_\_

***Please turn this form over and complete side two***

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Please fill out completely. *If there is nothing to list, write "N/A" (non applicable).* Today's Date: \_\_\_/\_\_\_/\_\_\_

## Vision Insurance: (Check all that apply):

VSP \_\_\_ VCP \_\_\_ BCBS \_\_\_ EYEMED \_\_\_ TRICARE \_\_\_ HEALTHNET \_\_\_ VCD \_\_\_ MEDICARE \_\_\_ CIGNA \_\_\_  
WORKERS COMP \_\_\_ NONE \_\_\_ OTHER \_\_\_\_\_

Primary member: \_\_\_\_\_ Patient's relationship to primary: Self / Spouse / Child / Other

Member ID #: \_\_\_\_\_ (circle one)

Primary member's DOB: \_\_\_/\_\_\_/\_\_\_

***We will need a copy of your vision insurance card to copy for the records if applicable.***

## Medical Insurance (Primary) :

Name of Medical Insurance: \_\_\_\_\_

Primary member name: \_\_\_\_\_

Patient's relationship to primary: Self / Spouse / Child / Other

Member ID/Social Security #: \_\_\_\_\_

Primary member's employer: \_\_\_\_\_

Primary member's DOB: \_\_\_/\_\_\_/\_\_\_

Office Use

Only Effective Date \_\_\_/\_\_\_/\_\_\_

Copay \$ \_\_\_\_\_

Exam:

Materials:

## Medical Insurance (Secondary) :

Name of Medical Insurance: \_\_\_\_\_

Primary member name: \_\_\_\_\_

Patient's relationship to primary: Self / Spouse / Child / Other

Member ID/Social Security #: \_\_\_\_\_

Primary member's employer: \_\_\_\_\_

Primary member's DOB: \_\_\_/\_\_\_/\_\_\_

Office Use

Only Effective Date \_\_\_/\_\_\_/\_\_\_

Copay \$ \_\_\_\_\_

Exam:

Materials:

***We will need a copy of your medical insurance card to copy for the records.***

**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.

We do not accept insurance assignments other than those above. If your insurance is not listed please ask the receptionist if we are a provider.

**Payment is required at the time of services rendered.**

Patient (or parent/legal guardian): (signature) \_\_\_\_\_ Date: \_\_\_\_\_