

WELCOME TO ESTRELLA EYECARE

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

Patient Information:

(Mr/Mrs/Miss/Ms/Dr) Patient Name: _____

Social Security# _____ Last, First MI Date of Birth: ___/___/___

Address: _____ Apt# _____ Phone: (____) _____ Home

City: _____ ST _____ Zip _____ Phone: (____) _____ Cell

Email: _____ Phone: (____) _____ Work

(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 / Other Spouse's name: _____

Patient / Parent Employment Information:

If child, name of parent: _____ Parent's DOB: ___/___/___

Employment Status: Full-Time ___ Part-Time ___ Student/Child ___ Retired ___ Not Employed ___

Employer: _____ Occupation/Job: _____

Receipt of Notice of Policy Practices & Consent Form

Effective date of notice: April 1, 2003

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form.

Please list any of those responsible individuals that you will allow personal information, glasses, or contact lenses to be released to by our office. Proper identification will be documented whenever information is released to any of the people listed below. Examples of those individuals might be: spouse, the other parent, older sibling(s), grandparent(s), stepparent, aunt/uncle, or other caregiver. Only the minimum necessary information will be provided.

Date	Names of those individuals allowed to receive personal patient information incl. glasses and contact lenses	Relationship to patient	Date of Birth	Any restrictions?

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from ESTRELLA EYECARE, and I allow those listed above to receive limited personal patient information in my absence.

Signature of Patient / Parent / Guardian

Date

Please turn this form over and complete side two

WELCOME TO ESTRELLA EYECARE

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: _____

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MEDICAL HISTORY

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

DATE: _____

SEX: Male Female

PATIENT NAME: _____

BIRTHDATE: _____

When was your last eye exam: _____ By whom? _____

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Are you interested in contact lenses? No Yes Are you interested in Colored contacts? No Yes

Name of Medical Doctor: _____ Dr.'s Phone No: (____) _____

Dr.'s FAX No: (____) _____

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

List any medications you currently take as well as eye drops: _____

List any eye injuries or eye surgeries (include which eye and date of occurrence(s): _____

Are you pregnant and/or nursing? No Yes N/A

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you'd prefer. YES, I would prefer to discuss my social history information directly with my doctor. (Check box)

Do you use cigarettes/tobacco? No Yes If yes, type/amount/how long? _____

Do you drink alcohol? No Yes If yes, type/amount/how long? _____

Do you use illegal drugs? No Yes If yes, type/amount/how long? _____

Please turn this form over and complete side two

REVIEW OF SYSTEMS

Do you or an immediate 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	FAMILY MEMBER Yes	EXPLAIN
EARS, NOSE, THROAT				
INTEGUMENTARY (<i>skin</i>)				
MENTAL (anxiety, depression)				
HEADACHES, MIGRAINES				
RESPIRATORY - Asthma				
RESPIRATORY- COPD				
HEART DISEASE				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
CANCER				
GASTROINTESTINAL				
GENITOURINARY				
ENDOCRINE (<i>glands</i>)				
Diabetes Mellitus				
Thyroid Disease				
Hormone Replacement, birth control				
BONES/JOINTS/MUSCLES (arthritis)				
LYMPHATIC/BLOOD				
ALLERGIC/IMMUNOLOGIC				
Allergies (Seasonal/Other)				
EYES:				
Blurred Vision				
Double Vision				
Blindness/Loss of vision				
Cataracts				
Crossed eyes				
Glaucoma				
Macular degeneration				
Retinal detachment/disease				
Eye surgery (cataract/LASIK/RK)				
Eye injuries				
OTHER				

Patient's Signature (or parent/legal guardian): _____ Date: ___/___/___

Doctor's Signature: _____ Date: _____