MIRA MESA OPTOMETRY

Patient Information and History

☐ Mrs. ☐ Ms. ☐ Mr. ☐ Dr.   ☐ Male ☐ Female   ☐ Single ☐ Married ☐ Divorced ☐ Widowed   Date of Birth _____/_____/_____

Last Name__________________ First Name __________________MI _____

Address__________________ City__________________ State_______ Zip _______________

Home # (_______)____________ Daytime # (_______)____________ Mobile # (_______)____________

Employer Name __________________ Occupation __________________

SSN # __________________

Preferred method of communication for appointment reminders and glasses/contacts ready?
(Please Circle) Home Mobile Email__________________

I have verified that there are NO CHANGES with my information.

20__ _______ Year Initials
20__ _______ Year Initials
20__ _______ Year Initials

VISION INSURANCE ☐ None ☐ VSP ☐ EyeMed ☐ MES ☐ Superior ☐ Other__________

☐ Dependent ☐ Spouse
☐ Self (*Same As Above*)__________________

Relationship to member | Member Name | Member Date of Birth | Member I.D. / Social Security Number

I have verified that there are NO CHANGES in my Vision Insurance.

20__ _______ Year Initials
20__ _______ Year Initials
20__ _______ Year Initials

PATIENT HEALTH HISTORY: ☐ NONE APPLY

Self	**Family History** *Please note relationship to you*
☐ Diabetes	☐ ____________
☐ High Blood Pressure	☐ ____________
☐ High Cholesterol	☐ ____________
☐ Heart Disease	☐ ____________
☐ Asthma / Lung Disease	☐ ____________
☐ Thyroid Disorder	☐ ____________
☐ Arthritis	☐ ____________
☐ Lupus	☐ ____________

Other __________________

Medications Taken (*including oral contraceptives, aspirin, over the counter meds and home remedies)*__________________

____

Any Allergies to Medications __________________

OCCULAR HEALTH HISTORY:

☐ NONE APPLY

Self	**Family History** *Please note relationship to you*
☐ Glaucoma	☐ ____________
☐ Macular Degeneration	☐ ____________
☐ Cataracts	☐ ____________
☐ Retinall Disease	☐ ____________
☐ Optic Nerve Disease	☐ ____________
☐ Eye Injury	☐ ____________
☐ Eye Infections	☐ ____________
☐ Blindness (Injury)	☐ ____________
☐ Blindness (Disease)	☐ ____________
☐ Lazy Eyes	☐ ____________

Other__________________

History of LASIK / Refractive Surgery? When?__________

Are you currently taking medications for your eyes? Y N

____

I have verified that there are NO CHANGES in Patient and Ocular Health History.

20__ _______ Year Initials
20__ _______ Year Initials
20__ _______ Year Initials

SOCIAL HISTORY: Are you pregnant and / or Nursing? ☐ No ☐ Yes If yes, how many weeks / months along are you?__________

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes (explain) __________

Do you drink alcohol? ☐ No ☐ Yes How often? ☐ Social use ☐ 1-2 drink daily ☐ Other __________

Do you use tobacco product? ☐ No ☐ Former user ☐ Yes How often? ☐ Less than 1pk / day ☐ 1-2pk / day ☐ More than 2pk / day

Do you use narcotic drugs? ☐ No ☐ Recreational use ☐ Chemical dependent ☐ Other __________

Have you ever been exposed to or infected with ? ☐ Decline to state

STD's ☐ No ☐ Yes __________   Blood Transfusion ☐ No ☐ Yes

HIV ☐ No ☐ Yes __________   Hepatitis A / B / C ☐ No ☐ Yes

I have verified that there are NO CHANGES in Social History.

20__ _______ Year Initials
20__ _______ Year Initials
20__ _______ Year Initials

PATIENT HISTORY By: By: By:

Last Eye Examination ☐ Never ☐ 1-2yr ☐ 3-4yr ☐ 5+ yr ☐ Dr. Guiang, Orlando ☐ Dr. Georgina Blanc ☐ Dr. ___________________

Last Medical Exam ☐ Never _____ / _____ / _____ Name of Medical Doctor __________________________ Dr.'s # __________________

Do you wear glasses? ☐ No ☐ Yes If yes, how old are your current pair of lenses? ☐ 1yr ☐ 2yr ☐ Other_____________

Have your eyes been dilated before? ☐ Yes ☐ No

CHIEF COMPLAINT OR HISTORY OF PRESENT ILLNESS *Please provide us the reason for your visit and the symptoms you may be experiencing:*

Reason for your visit? ☐ Routine eye exam ☐ Routine contact lens exam ☐ Interested in LASIK ☐ Other ______________________________

OCULAR SYMPTOMS ☐ NONE, otherwise proceed below:

☐ Blurry Vision Distance	☐ Double Vision	☐ Eye Pain / Soreness	☐ Glare / Light Sensitivity	☐ Tired Eyes
☐ Blurry Vision Near	☐ Distortion	☐ Foreign Body Sensation	☐ Itching	
☐ Computer Distance	☐ Thick Discharge	☐ Frequent / Severe Headaches	☐ Lid Twitching	
☐ Blurry Night Vision	☐ Watery Discharge	☐ Flashes	☐ Redness	
☐ Burning	☐ Dryness	☐ Floaters	☐ Sudden Vision Loss	

COMPUTER RELATED PROBLEMS Do you work on a computer? ☐ Yes ☐ No How many hours?_______ Approximate distance from screen______

Do you have any of the following when working on a computer? Mark all that applies: ☐ Headaches ☐ Burning ☐ Redness ☐ Stinging ☐ Tearing ☐ Blurred

FOR CONTACT LENS PATIENTS ONLY Last worn routinely?......☐ Just today…….☐ Other____________ Reason if discontinued ______________________

How many days a week do you wear them?...........☐ Everyday…….☐ 2-3 times / week…….☐ Only occasionally………….☐ Other_____________________

Any problems with your lenses: ☐ Blurred Vision…..☐ Foggy Vision ……….☐ Dryness…………☐ Overall Discomfort…….☐ Other____________________

Are you sleeping in your lenses? ☐ Yes ☐ No If so, how often………. ☐ Every night……...☐ 2-3 times / wk…. ☐ Only on occasion

Type of lenses:…… ☐ Soft………………..☐ Gas Permeable (Hard)……….☐ Toric (for astigmatism)……………...☐ Bifocal……………...☐ Monovision

How often are your lenses replaced?..... ☐ Daily……...☐ 2 Weeks ..……. ☐ Monthly…….. ☐ Every 3 mos……….☐ Non-disposable / Yearly

Do you know the brand name, if so please indicate ________________________________ Are you interested in changing your eye color? ☐ Yes ☐ No

The Health Insurance Portability and Accountability Act (HIPAA)

We are obligated by law to give you notice of our privacy practices. I acknowledge that I read and understand Mira Mesa Optometry's Notice of Privacy Practices, and will be given a copy per my request.

Patient Initials X ___________

FINANCIAL RESPONSIBILITY

- I authorize Mira Mesa Optometry to use my name on all claims or documents that relate to health insurance benefits due to me and my dependents.
- I authorize the release of any information related to any claims to all relavant insurance companies or other parties.
- I understand I am financially responsible, whether my insurance company pays or not, for all charges incurred by me, I further agree that in the event of non-payment I will bear the cost of collection and / or costs and responsible legal fees should such action be required.
- I understand a $25 fee will be charged on returned checks.
- I understand that payment is due at the time services are rendered.
- I permit a copy of this authorization to be used in place of the original.
- All sales are FINAL

Patient Initials X ___________

I hereby authorize my doctor to furnish and disclose all facts concerning this exam to my insurance. Signature and Date is required once every year.

X____ X____

Patient Signature (If Under 17, Parent/Guardian) **Date** **Patient Signature** (If Under 17, Parent/Guardian) **Date**

X____ X____

Patient Signature (If Under 17, Parent/Guardian) **Date** **Patient Signature** (If Under 17, Parent/Guardian) **Date**

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