WELCOME TO SAN RAMON FAMILY OPTOMETRY

This questionnaire will be kept confidential. Please be as accurate as possible.

Patient Name: _____ Nickname:_____[ ] M [ ] F DOB: ____/____/_____ Age:_____
Home Address: _____ City _____ Zip _____
Do you work at a computer? [ ] Y [ ] N If yes, how many hours a day: _____ Are you interested in LASIK: [ ] Y [ ] N

VERY IMPORTANT! NEW PATIENTS, WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
Name of friend/relative: _____ [ ] VSP [ ] Internet [ ] Walk In [ ] Other Doctor _____

For the Healthcare Initiative Meaningful Use, we must collect the following information, please check the one that applies:							
Race	☐ American Indian/Alaska Native	☐Asian	☐ Black/African American	☐ Native Hawaian/Pacific Islander	☐White	☐ Other	☐ Decline
Ethnicity	☐ Non Hispanic or Latino	☐ Hispanic or Latino	☐ Unknown	☐ Decline to Answer	**Primary Language:**		

	Primary (Please check one)	Prefered Source of communication				May we contact you by:			
Home Phone: ( ) -	☐	Home Phone	☐	US Mail	☐	Text	☐ Y	☐ N	Cell Provider:
Work Phone: ( ) -	☐	Work Phone	☐	Email	☐	Email	☐ Y	☐ N	
Cell Phone: ( ) -	☐	Cell Phone	☐	Text	☐	Email Address:		@	.com

Insurance Provider
Vision Insurance Provider: ☐ VSP ☐ Eyemed ☐ MES ☐ Superior ☐ Other: _____
Medical Insurance Provider: ☐ Blue Cross ☐ Cigna ☐ Aetna ☐ United Healthcare Other: _____ ☐ PPO ☐ HMO
Primary Member's Name: _____ DOB: _____/_____/_____ Last 4 of SS# _____
Date of last eye examination: _____ Location: _____
Do you wear glasses: [ ] Y [ ] N Age of glasses: _____ Do you wear contacts: [ ] Y [ ] N Type/Brand _____
Date of last physical examination: _____ Name if medical doctor: _____City _____
Current Medications: _____ Have you had any head/eye injuries or surgeries? _____
Do you have any allergies to medications: [ ] Y [ ] N If yes, to which ones: _____
Do you have any special needs our office should be aware of?_____

Social History:					
Height:		Weight:		☐ Decline to answer	
Do you have difficulty while driving	☐ Y	☐ N	Explain:		
Do you use tobacco?	☐ Y	☐ N	How much?		
Do you drink alcohol?	☐ Y	☐ N	Amount?		
Do you use narcotics?	☐ Y	☐ N	Type/Amount/How long:		
Any history with being affected with:	☐ Gonorrhea	☐ Hepatitis	☐ HIV	☐ Syphilis	☐ Herpes

Medical History: Please indicate if you or any family members, living or deceased, have had any of the following conditions:					
Glaucoma	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Cataracts	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Macular Degeneration	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Retinal Disease	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Blindness	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Strabismus (Eye muscle issue)	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Amblyopia (Lazy eye)	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Diabetes	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Diabetic Retinopathy	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Dry Eye	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
Refractive	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
High Blood Pressure	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:
High Cholesterol	☐ Self	☐ Mother	☐ Father	☐ Other:	Explain:

Review of Symptoms: Please check if you have had issues in any of the following areas and write brief explanation					
Constitution (general health)	☐		Integumentary (skin)	☐	
Cardiovascular	☐		Neurological	☐	
Earns, Nose, Mouth, Throat	☐		Psychiatric	☐	
Respiratory	☐		Endocrine (thyroid/hormones)	☐	
Gastrointestinal	☐		Hematologic/Immunologic	☐	
Genitourinary	☐		Allergic/Immunologic	☐	
Musculoskeletal	☐		Other Health Issues	☐	

Account Responsible: If patient is a minor, please fill out the following
Print Name: _____ Signature: _____ Relationship: _____DOB: _____
Address:_____SS #_____

PAYMENT TERMS: We accept most major credit cards, and also offer electronic check payment or CareCredit. We are happy to assist you in filing your insurance claim, If your insurance does not pay the anticipated amount, or pays you directly, we ask that you agree to pay the balance.
Office policy is that full payment is due at the time services are rendered
I have read and agree to all provisions in full of the payment terms and office policy:

_____	_____	_____	_____
Signature of patient/Guardian	Print name	Relationship	Date