

eYe cLinic OPTOMETRY



Welcome to our office!

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT NAME: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

HOME ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

HOME TELEPHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ MALE / FEMALE

OCCUPATION: \_\_\_\_\_ (Circle Answer): Single Married Separated Divorced Widowed

PARENT/GARDIAN: \_\_\_\_\_  
(Responsible for payment) (LAST) (FIRST)

SOCIAL SECUIRITY#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DRIVER'S LIC. /ST ID#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK TELEPHONE: ( ) \_\_\_\_\_

E-MAIL: \_\_\_\_\_

PERSON WE CAN CONTACT IN CASE OF EMERGENCY:

NAME \_\_\_\_\_ TEL# ( ) \_\_\_\_\_ - \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

METHOD OF PAYMENT (NO CHECKS):

CASH ATM VISA MASTERCARD DISCOVER AMX CARECREDIT OTHER

INSURANCE: (Circle Answer)

MEDI-CAL MEDI-CARE VSP BLUE CROSS CIGNA AETNA SAFEGUARD EyeMed HEALTH NET MARCH VISION  
DAVIS VISION COMPBENEFITS SUPERIOR VISION OTHER

HOW DID YOU HEAR ABOUT OUR OFFICE?

- \_\_\_\_ SIGN ON THIS BUILDING
- \_\_\_\_ FLYER
- \_\_\_\_ NEWSPAPER
- \_\_\_\_ RADIO
- \_\_\_\_ TV/Cable
- \_\_\_\_ INTERNET

- INSURANCE PROVIDER LIST: \_\_\_\_\_
- REFERRED BY DOCTOR: \_\_\_\_\_
- REFERRED BY SCHOOL: \_\_\_\_\_
- REFERRED BY PATIENT: \_\_\_\_\_
- WHAT PATIENT: \_\_\_\_\_
- OTHER: \_\_\_\_\_

WE APPRECIATE THE REFERRAL OF FRIENDS AND FAMILY MEMBERS TO OUR OFFICE. THANK YOU!!!

REASON FOR VISIT: (CIRCLE ANSWERS) (GLASSES) / (CONTACT LENSES) / (EYE SURGERY CONSULT)

(BLURRED VISION) / (EYE ITICH) / (EYE IRRITATION) / (RED EYE) / (EYE PAIN) / (EYE INFECTION) / (EYE INJURY)

OTHER: \_\_\_\_\_

CONFIDENTIAL

LEONIDAS A. JOHNSON, O.D., A PROFESSIONAL CORPORATION

Dr. Review \_\_\_\_\_ Date \_\_\_\_\_

# eYe cLinic OPTOMETRY

Ethnicity: African American, American Indian, Asian, Caucasian, Ethiopian, Hispanic, Middle Eastern, Mediterranean, Pacific Islander, Pilipino

**LAST EYE EXAM:**      1-2 YEARS      3-4 YEARS      OVER 5 YEARS      OVER 10 YEARS      NEVER

## MEDICAL HISTORY

- \_\_\_\_\_ DIABETES
- \_\_\_\_\_ HIGH BLOOD PRESSURE
- \_\_\_\_\_ ASTHMA
- \_\_\_\_\_ HEART CONDITION
- \_\_\_\_\_ ARTHRITIS
- \_\_\_\_\_ THYROID
- \_\_\_\_\_ CANCER
- \_\_\_\_\_ EYE SURGERY
- \_\_\_\_\_ CATARACTS
- \_\_\_\_\_ GLAUCOMA
- \_\_\_\_\_ STRABISMUS
- \_\_\_\_\_ DRUG ALLERGY \_\_\_\_\_

## FAMILY MEDICAL HISTORY

- \_\_\_\_\_ DIABETES
- \_\_\_\_\_ HIGH BLOOD PRESSURE
- \_\_\_\_\_ HEART CONDITION
- \_\_\_\_\_ CANCER
- \_\_\_\_\_ BLINDNESS
- \_\_\_\_\_ CATARACTS
- \_\_\_\_\_ GLAUCOMA
- \_\_\_\_\_ STRABISMUS
- \_\_\_\_\_ OTHER \_\_\_\_\_

## SOCIAL HISTORY

- \_\_\_\_\_ HAVE DRIVING LICENSE
- \_\_\_\_\_ USE TOBACCO
- \_\_\_\_\_ DRINK ALCHOL
- \_\_\_\_\_ USE ILLEGAL DRUGS
- \_\_\_\_\_ HIV+
- \_\_\_\_\_ STD
- \_\_\_\_\_ ADDICTION
- \_\_\_\_\_ DEPRESSION
- \_\_\_\_\_ STRESS
- \_\_\_\_\_ FAITH COMMUNITY
- \_\_\_\_\_ HEPATITIS
- \_\_\_\_\_ OTHER \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

## REVIEW OF SYSTEMS: DO YOU HAVE ANY PROBLEMS IN THE FOLLOWING AREAS? (CIRCLE ANSWERS)

- Y / N **ALLERGY:** Dairy Products, Dust, Environmental, Foods, Molds/Mildew, Pollens, Shellfish
- Y / N **CARDIOVASCULAR:** Angina, Arrhythmia, Heart Disease, Cholesterol, Murmur, Palpitations, Hypertension, Stroke
- Y / N **CONSTITUTION:** Appetite excess /loss, Blackouts, Fatigue, Fever, Nausea, Thirst excess, Urination excess, Weight loss/gain
- Y / N **ENDOCRINE:** Crohn's Disease, Diabetes, Gout, Hypoglycemia, Pituitary Disorder, Renal Disease, Thyroid Disorder
- Y / N **EYES:** Sudden Vision Loss, Double Vision, Flashes, Spots, Light Sensitive, Glare, Burn, Gritty, Sties, Eye Fatigue
- Y / N **GASTROINTESTINAL:** Acid-Reflux, Constipation, Colitis, Diarrhea, Gall stones, Hepatitis, Inflammatory Bowel, Ulcer
- Y / N **GENITOURNARY:** Bladder Infection, Impotence, Kidney Stones, Ovarian, Prostrate, Syphilis, Gonorrhea, Chlamydia, Herpes
- Y / N **HEAD/EARS/NOSE/THROAT/MOUTH:** Chronic Cough, Dry Mouth, Dental Disorder, Ear Infection, Headache, Head Cold
- Y / N **HEMATOLOGIC/LYMPHATIC:** Anemia, Hodgkin's, Leukemia, Sickle Cell, Temporal Arteritis, Bleeding Disorder
- Y / N **IMMUNOLOGIC:** HIV, AIDS, Multiple Sclerosis, Myasthenia Gravis, Sarcoidosis, Sjogren, Tuberculosis
- Y / N **INTEGUMENTARY (SKIN):** Acne, Albinism, Dermatitis, Eczema, Lupus, Ocular Rosacea, Psoriasis, Rash, Sunburn, Warts
- Y / N **MUSCULOSKELETAL:** Alkalosis Spondylitis, Arthritis, Down's, Marfan's, Muscular Dystrophy, Myasthenia, Osteoporosis
- Y / N **NEUROLOGICAL:** Bell's, Cerebral Palsy, Migraines, Epilepsy, Multiple Sclerosis, Epilepsy, Parkinson's, Mental Challenged
- Y / N **PSYCHIATRIC:** Schizophrenia, Bi-Polar, Substance Abuse, Anxiety, Panic, Gambling, Eating, Sexual, Sleep, Impulse/Control
- Y / N **RESPIRATORY:** Asthma, Bronchitis, COPD, Emphysema, Lung Disease, Tuberculosis, Sarcoid, Respiratory Dysfunction

COMMENTS: \_\_\_\_\_

## AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN INSURANCE BENEFITS

I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY ACQUIRED INFORMATION IN THE COURSE OF MY EXAMINATION OR TREATMENT, AND I HEREBY ASSIGN ALL PAYMENTS OF MEDICAL SERVICES RENDRED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

IN THE COURSE OF PROVIDING SERIVCES 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, OBTAIN PAYMENT FOR OUR SERVICES, AND TO CONDUCT HEALTHCARE OPERATIONS INVOLVING OUR OFFICE. THE NOTICE OF PRIVACY PRACTICES DESCRIBES THESE USES AND DISCLOSURES IN DETAIL.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

CONFIDENTIAL

Dr. Review \_\_\_\_\_ Date \_\_\_\_\_

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