WELCOME TO OUR OFFICE

BEACHSIDE OPTOMETRY INC.

Kevin Germundsen O.D.
M.Linda Arboleda O.D.

Patient: Last______________________First__________________MI____
Today's Date__________________
Salutations (circle) Dr. Mr. Mrs. Miss Ms. Master other___
Date of birth_________________Social Security #_____________________
Address____
City____________________________State_____Zip____________
Telephone:Home___________Work____________Cell___________
Email____
Employer (or School)_______________________________
Occupation_______________________
How Referred(circle) Insurance, Yellow pages, Walk by, Web site, Friend or Family
Who may we thank for referring you to our office?____________________________

INSURANCE INFORMATION

Name of Insurance Subscriber____________________SS#____________________
Name of Vision Insurance_______________________ID#_____________________
Name and Policy# of Major Medical Insurance________________ ID#____________
Family or Primary Care Physician__________________________
Do you require a referral from your M.D. for eye care service?
NOTE: Major medical insurance may pay for certain eye health services.
How will you settle you account today? (circle) cash, check, credit card

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with ____________________ and assign to Dr. Germundsen or Dr. Arboleda all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
I authorize the use of my signature on all insurance submissions. No refunds are given on glasses or contacts already made by our laboratory; remake or exchange only. All orders not dispensed within 30 days of notification will forfeit deposit unless prior arrangements are made.

Responsible party signature________________________Date______
Relationship____________________________

CONTINUE ON BACK SIDE

EYE HEALTH HISTORY

What is the major purpose of this visit? ______________________________

The information on this form is confidential and critical to the evaluation of your vision & health.

Do you wear glasses? Y/N
Do you have prescription sunglasses? Y/N
Do you wear contact lenses? Y/N
Are you satisfied with the vision and comfort? Y/N
Do you prefer not to wear your glasses at times? Y/N
Do you have a spare pair of prescription glasses? Y/N

Date of last eye exam__________

Circle if you have any of the following?
Double vision / Occasional dryness/ Blurry vision / Flash of light
Sensitivity of light / Burning / Floaters/spots / Tearing / Grittiness
Trouble seeing at night / Crossed eye/eye turn / Eye infection

HEALTH HISTORY

(Circle the yes if you have any of the following)

	Yourself	**Family**		**Yourself**	**Family**
AIDS/HIV	YES	YES	High Blood Pressure	YES	YES
Arthritis	YES	YES	Hepatitis (Type)	YES	YES
Asthma	YES	YES	Kidney Disease	YES	YES
Bleeding	YES	YES	Lazy Eye	YES	YES
Blindness	YES	YES	Migraine Headaches	YES	YES
Cancer	YES	YES	Retinal Disease	YES	YES
Cataracts	YES	YES	Shingles	YES	YES
Chemical Dependency	YES	YES	Skin Condition	YES	YES
Diabetes	YES	YES	Stroke	YES	YES
Drug Sensitivity	YES	YES	Thyroid Condition	YES	YES
Emphysema	YES	YES	Tuberculosis	YES	YES
Epilepsy	YES	YES	Eye Turn	YES	YES
Eye Surgery	YES	YES	Heart Condition	YES	YES
Glaucoma	YES	YES	Rheumatic Fever	YES	YES
Macular Degeneration	YES	YES	Eye Injury	YES	YES

CURRENT MEDICATIONS (RX OR OVER THE COUNTER) List name of medication including eye drops, vitamins and birth control pills

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Allergies to Medications______________________________