SOUTH PASADENA OPTOMETRIC GROUP

Patient Information

Salutation ☐Ms ☐Mrs ☐Mr | Dr Cred._____

First Name _____

Last Name _____

Middle Initial _____ **Nickname**_____

Date of Birth (MM/DD/CCYY) _____

SSN (Last four [4] digits) _____

Sex ☐M | F☐ New Patient | Established Patient

Language_____**Race(s)**_____

☐Hispanic or Latino ☐Not Hispanic or Latino

Emergency Contact_____

Phone _____

Relationship to Patient: _____

Release Medical Information to Contact? ☐Yes | No☐

Address: _____

City: _____

State/Province:_____ Zip:_____

MARITAL STATUS: S / M / D/ W ☐ ☐ ☐ ☐

Preferred Method of Contact: Home | Work | Cell | Email

Home: _____

Work: _____

Cell: _____

Email: _____

May we text you notifications of order status? Yes | No

Occupation: _____

Employer: _____

Notice of Privacy Practices: I have read and/or received a copy of the South Pasadena Optometric Group's Notice of Privacy Practices.

Signature: _____ **Date:**_____

Financial Responsibility and Health Insurance

Payment is expected at time of service. Who is financially responsible for payment?

Last: _____ **First:**_____ **M:** _____ **Relationship to Patient:**_____**SSN:**_____

Address: _____

City: _____

State: _____**Zip:**_____

Home Phone: (_____) _____

Work Phone: (_____) _____

Email: _____

Health Insurance Company: _____ **Name of Insured:** _____

DOB _____ **Policy No.**_____ **Group No.** _____ **Group Name:** _____

Whom do we thank for referring you to our office? _____

Do you have other family members who are patients in our office? ☐Yes | No☐

If yes, please list their names: _____

I understand and agree that (**regardless of my insurance status**) I am responsible for the balance of my account for any services rendered. I will notify you of any changes in my status or in my information provided above.

I authorize the release of any medical or other information necessary to process my insurance claims. I instruct and direct my insurance carrier to make payment to South Pasadena Optometric Group, Inc. for the benefits allowable and otherwise payable under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of the Assignment shall be considered as effective and valid as the original.

Patient's, or responsible party's signature: _____ **Date:** _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____ / _____ / 20_____

Eye History Last Eye Exam: _____ mo / _____ yr

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? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other

Other Eye History _____

Medical History Last Medical Exam: _____ mo / _____ yr

List all major injuries, surgeries and/or hospitalization you have had: _____

_____

Are you pregnant and/or nursing? ❒ no ❒ yes

Do you have any allergies to medications? ❒ no ❒ yes If yes, list them: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

PERSONAL AND FAMILY HISTORY

Please note self and family history (**Parents, Grandparents, Siblings, Children; Living or Deceased**) for the following conditions:

DISEASE/CONDITION	SELF	PARENT		OTHER BLOOD RELATIVE (siblings, grandparents, etc.)
		Mother	Father	
Blindness	❒	❒	❒	
Cataract	❒	❒	❒	
Cross Eyes	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment/Disease	❒	❒	❒	
Headaches	❒	❒	❒	
Seizures	❒	❒	❒	
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
High Cholesterol	❒	❒	❒	
HIV-positive	❒	❒	❒	
Lupus	❒	❒	❒	
Rheumatoid Arthritis	❒	❒	❒	
Thyroid Disease	❒	❒	❒	
Psychiatric	❒	❒	❒	
OTHER	❒	❒	❒	

Social History (*This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.)*

Do you use tobacco products? ❒ 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: _____