SOUTH PASADENA OPTOMETRIC GROUP

Patient Information

Last: _____ First _____ Middle _____ Mr. Mrs. Ms. Dr.

Address: _____ Home Phone: (____) _____

City _____ State _____ Zip _____ Work Phone: (____) _____

Birth date: _____ Age _____ Sex: M F Cell Phone: (____) _____

Marital Status: S M Other _____ email: _____

Employer Name: _____

Occupation: _____ Soc. Security No. _____

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: _____

Financial Responsibility

Payment is expected at time of service. We accept cash, checks, Visa, MasterCard, and Discover.
Who is financially responsible for our professional services?

Name: Last: _____ First: _____ Middle: _____

Address: _____

City _____ State _____ Zip _____

Vision Insurance Information: VSP MESC Davis Facey Medicare Medi-Cal Other

Covered Member _____ ID Number _____

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 professional or medical 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:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the South Pasadena Optometric Group's Notice of Privacy Practices.

Signature: _____ **Date:** _____

SOUTH PASADENA OPTOMETRIC GROUP

729 Mission St. Suite 200 South Pasadena, CA 91030

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

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

_____

_____

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

Personal and Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	WHO? (SELF, PARENTS, SIBLINGS…)
Blindness	❒	❒	❒	
Cataract	❒	❒	❒	
Cross Eyes	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment/Disease	❒	❒	❒	
Headaches	❒	❒	❒	
Seizures	❒	❒	❒	
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
Hepatitis	❒	❒	❒	
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: _____