Welcome To Cameron Park EyeCare Optometric Center

Date_____

Due to HIPPA, we are required to have every patient complete this form. It is often necessary to use and disclose your health information in order to treat you, to 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. A copy can be provided upon request. All information is strictly confidential.

Please circle: Mr. Mrs. Ms. Miss Dr.	Age:
Last Name_____	E-mail_____
First Name_____MI_____	Phone (H)_____
Address_____	(W)_____
City_____	(C)_____
State_____ Zip_____	Soc. Sec. #_____
Occupation_____	Birthdate_____
Employer_____	Spouse Name_____

Emergency Contact Person_____Phone_____

How did you hear about our office? _____

Medical History:

Are you allergic to any medications? __Yes __No Please list_____

List any medications you take_____

List all major injuries or surgeries you had_____

Are you pregnant or nursing? __Yes __No Date of last eye exam_____

Do you wear glasses? __Yes __No Age of glasses_____

Are you interested in new contact lenses? __Yes __No Do you wear contacts? __Yes __No

Type of Contact lenses: _____Soft _____astigmatic _____weekly _____monthly
_____daily _____monovision _____bifocal _____Rigid

Please check all that applies to you: _____Crossed eyes _____ Macular Degeneration
_____Glaucoma _____Retinal disease _____Cataracts _____Eye infections/Eye injury

Family History:

Please note any family history (parents, grandparents, siblings) for the following conditions:

Disease/Condition	**No**	**Yes**	**Who?**
Blindness			
Cataract			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			
Arthritis			
Diabetes			
High Blood Pressure			
Other			

Do you have visual difficulty when driving? ____Yes ____No

If yes, Please describe_____

Review of Systems:

Gastrointestinal		*Nervous*		*Mental*	
Ears/Nose/Throat		*Genitals/Kidney/Bladder*		*Endocrine/Glands*	
Cardiovascular		*Arthritis/Muscle/Joint pain*		*Blood/Lymph*	
Respiratoy		*Allergic/Immunology*		*Eyes*	

Please check if you have problems with any of the above systems and explain_____

_____

What kind of insurance do you have? _____VSP _____Eyemed _____Medicare
_____None Other_____

Name of person responsible for payment_____

Payment policy:

Full payment is required at time of service or order. All sales are final and non-refundable. Our staff can bill your insurance, however it is your responsibility to know your coverage. You are financially responsible for anything not covered by your insurance. Your signature below confirms that you understand and agree with the payment and HIPPA policy. If under 18 years of age a guardian must sign.

Signature_____ Date_____