

Welcome To Our Office

Courtney Chavez ,OD

Date _____

Last Name _____ First Name _____ MI _____

Birth Date _____ Age _____ Name of Legal Guardian _____

Address _____ City _____ State _____ Zip _____

Home Ph # _____ Cell Ph # _____ Occupation _____

Employer _____ Marital Status Married Single

Male Female Email _____

Emergency Contact _____ Relationship _____ Ph# _____

If you are using your insurance today please fill out the following: Insurance Company: _____

Primary Insured's Name: _____ Primary Insured's DOB: _____

Primary Insured's SSN/Member ID: _____ Patients SSN: _____

I authorize the vision care staff to perform the necessary health care services I or my child may need. I authorize Chavez Family Eye Care to bill my insurance for services rendered. I authorize payment of benefits from my insurance company to be sent to Chavez Family Eye Care. I understand that I am solely responsible to pay for any services performed that are not covered by my insurance.

I authorize the release of my medical information to any agency necessary to determine payment of benefits, utilization or compliance.

I have read and understand the financial policy, and agree to be bound by the terms.

HIPAA Compliance Acknowledgement

A laminated copy of the offices Notice of Privacy Practice has been provided to me and I understand that it is my right to have a take home copy.

Patient/Guardian Signature _____ Date: _____

Reason for today's visit

(Check all that apply)

Routine Exam

I want a glasses prescription

I want a contact lens prescription

Vision Problem

Red Eye

Other (Please Explain) _____

Previous Eye history

Have you been seen at this location? Yes No

Date of last exam _____ Dr. _____

Do you wear contact lenses? Yes No

Brand of contacts _____

Eye Injuries? _____

Eye Diseases? _____

Eye Surgery? _____

Family Medical History

(Mother, Father, Brothers, Sisters, Grandparents)

___ Diabetes ___ High blood pressure ___ Glaucoma ___ Retinal disease ___ Macular disease ___ Heart Disease
___ Stroke ___ Asthma ___ Arthritis ___ Tumor ___ Cancer ___ Bleeding disorder ___ Multiple Sclerosis
___ Color blindness ___ Night blindness ___ Lazy/Crossed eye ___ Cataracts ___ Eye/Muscle imbalance

Medical Information

Primary care doctor _____

List of medications (include non-prescription)

Systems Review

(Check all that apply, past or present or indicate non applicable)

Eyes: ___ Cataracts ___ Glaucoma ___ Dry Eyes
___ Macular Degeneration ___ Detached Retina
___ Diabetic Retinopathy ___ Blocked Tear Duct
Other _____

Ears, Nose & Throat: ___ Throat Condition
___ Nose Condition ___ Cold Sore ___ Hay Fever
___ Sinus Disease ___ Ear Condition
Other _____

Muscle & Joints: ___ Arthritis ___ Numbness
___ Artificial Joints ___ Rheumatism ___ Convulsions
Other _____

Blood: ___ Anemia ___ Hemophilia ___ Sickle Cell
___ Leukemia ___ Clotting
Other _____

Endocrine : ___ Diabetes
Other _____

Neurological: ___ Headache ___ Migraine
___ Weakness ___ Paralysis
Other _____

Heart: ___ Heart Attack ___ Congenital Heart Condition
___ Heart Murmur ___ High Blood Pressure ___ Angina
___ Heart Failure ___ Rheumatic Fever
Other _____

Respiratory: ___ Cough ___ Asthma ___ Emphysema
___ TB Other _____

Skin: ___ Hives ___ Bruise Easily ___ Rash
Other _____

Kidneys: ___ Kidney Disease ___ Bladder Problems
Other _____

Hormone: ___ Thyroid
Other _____

Psychiatric: ___ Anxiety ___ Depression
Other _____

Infections: ___ HIV ___ Aids ___ Hepatitis
Other _____

Cancer: _____
