3185 Old Conejo Road
Newbury Park, CA 91320

Dr. Kevin K. Hirano
Optometrist

Phone (805) 499-0454
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GENERAL PATIENT INFORMATION

Circle:Mr./Mrs./Ms./Miss Name:Last_____ First_____ M.I._____

Address_____ City_____ State_____ Zip_____

Home(_____)_____ Cell(_____)_____ Work(_____)_____ Primary: home/cell/work

SSN_____ Date of Birth_____ Employer_____ Occupation_____

E-mail_____ Name of Vision Insurance Company_____

In case of emergency, contact:_____ Relationship_____ Phone(_____)_____

Referred by_____

By signing below, I understand that I am financially responsible for any charges not covered by my insurance. It is my responsibility for knowing what vision insurance I have, and whether or not Dr. Kevin K. Hirano is a covered doctor under my plan. I also understand that if I am unaware of what insurance company I am covered under, I may be responsible for payment in full at the time services are rendered.

Signed_____ Date_____

MEDICAL HEALTH HISTORY

1. Do you or have you ever had any serious EYE HEALTH related problems (injuries, surgeries or diseases)? YES / NO. If yes, please explain:_____

2. Have you ever experienced any of the following (under normal vision conditions): bright flashes of light in your vision? YES / NO. small spots or lines floating through your vision? YES / NO. any other unusual symptoms? YES / NO. If yes, please explain:

_____

_____

3. Do you have any general health related issues (diabetes, diabetic retinopathy, high blood pressure, high cholesterol, etc.)? YES / NO. If yes, please list:

_____

_____

4. Are you currently taking any prescription or non-prescription medication? YES / NO. If yes, please list each medication and reason for taking:_____

_____

5. Do you have any allergies to medication? YES / NO. If yes, please list:_____

6. Do you have seasonal allergies? YES / NO.

7. Female, are you pregnant? YES / NO. Breastfeeding? YES / NO.

8. Do you smoke? YES / NO.

9. Is there any FAMILY (blood related) history of any of the following eye health problems? Please check all that apply and list their relationship to you:

YES	NO		Relationship to you
____	____	Glaucoma	_____
____	____	Cataracts	_____
____	____	Retinal tear/detachment	_____
____	____	Macular Degeneration	_____
____	____	Other:_____	_____

Date Reviewed/Initials: