TOTAL VISION™

665 San Rodolfo Dr. Suite 119 ~ Solana Beach ~ CA, 92075

Patient Questionnaire

Last Name: _____ First: _____ MI:____

Date of Birth: _____ Age: _____ SS#_____ Sex: Male / Female

Mailing Address: _____ City: _____ Zip: _____

Home Phone:_____ Cell: _____ Work: _____

Email: _____ Spouse:_____

Occupation: _____ Employer: _____

Parent Name (if under 18)_____ Signature:_____

Vision Insurance: ***VSP*** ***EYEMED*** ***MEDICAL EYE SERVICES*** ***SUPERIOR VISION***

Insured's Name: _____ ID# _____

Date of Birth: _____ SS#_____

Patient Relationship to Insured: Self Spouse Child

Medical Insurance: ***MEDICARE*** ***Blue Shield*** ***Aetna*** ***Anthem Blue Cross*** Other:_____

Insured's Name: _____ Id#: _____

Date of Birth: _____ SS#: _____

Patient Relationship to Insured: Self Spouse Child

For Medicare patients, do you have a secondary to you Medicare or a part B? YES NO

If yes please list:_____ Id#_____

(Please present your medical insurance card so we can keep a current copy on file. Thank you.)

How did you hear about our office? *(Please check all that apply)*

○ *YELP* ○ *Google* ○ *Insurance* ○ *Internet* ○ *Community Event* ○ *Walk-In*
○ *Friend/Relative:*_____ ○ *Physician:* _____

Eye Examination History

Date Of last Eye Exam: _____ Name of last Optometrist: _____

Do you wear Glasses? YES NO How long have you had your glasses? : _____

Do you wear Contacts? YES NO Please list brand:_____

Please complete the information on the back >

Medical Information (please check all that apply)

☐ *Allergies* ☐ *Heart Disease* ☐ *Diabetes* ☐ *Cataracts* ☐*High Blood Pressure*

☐ *Arthritis* ☐ *Glaucoma* ☐ *Asthma* ☐ *Eye Injury* ☐ *Macular Degeneration*

☐ *Cancer* ☐ *Thyroid* ☐ *Kindey* ☐ *Cholesterol* ☐ *Skin Disorder*

Are you currently taking any medications?(please list below or provide a copy of your list)

_____

_____

Are You Allergic to any medications? (Please List) _____

General Vision Information

Family Medical History (please circle all that apply to *immediate* family ONLY & list relation)

Cataracts Relation_____ **Glaucoma** Relation _____

Macular Degeneration Relation _____ **Diabetes** Relation _____

Retinal Detachment Relation _____ **High B/P** Relation _____

Do you experience the following: (please check all that apply)

☐ Burning Eyes ☐ Grittiness ☐ Excessive watering ☐ Light Sensitivity ☐ Itching

☐ Blurry Vision ☐ Eye Strain ☐ Flashes of Light ☐ Headaches ☐ Floaters

☐ Double Vision ☐ Glare/Reflection

How many hours do you work on the computer? _____

What are your hobbies/ sport activities? _____

Are you interested in more information on Lasik Surgery? _____

Privacy Notice: This office's privacy practices are in accordance with HIPPA regulations. You may obtain a copy of our privacy practices upon request. Your signature here indicates you have been advised of the availability of this information.

I understand that if my insurance eligibility cannot be verified, or if my insurance does not pay the amount due, that I will be financially responsible for all services performed at Eye Gallery Optometry.

Signature: _____ Date: _____

Thank you for choosing Eye Gallery Optometry for all of your vision needs!