



Rancho Santa Margarita Optometry

30212 Tomas, Ste. 170, Rancho Santa Margarita, Ca 92688

Welcome and thank you for seeing us today! We will always do our best to serve you.

Patient Name: _____ Sex: M F D.O.B: _____
 Age: _____ S.S.#: _____ Drivers License#: _____
 Address: _____ City: _____ ZIP: _____
 Hm Phone: _____ Pgr. / Cell #: _____ Wk Phone: _____
 Employer: _____ Occupation: _____ E-mail : _____ @ _____

GENERAL INFORMATION

Reason for today's visit: (Describe the symptoms you [or your child] are having, and when they started: _____)

Names of family members we care for: _____ Referred By: _____

Are you interested in? LASIK Glasses Contacts General exam Other: _____

GENERAL & NOCULAR HEALTH HISTORY

Do you currently or have you in the past had any of the following:

- Diabetes High Blood Pressure Glaucoma Stroke Heart Disease Tuberculosis Lazy Eye
- Cancer: *Type* _____ In remission? Yes No Lupus Rheumatoid Arthritis
- Cataract Surgery Refractive Surgery Eye Muscle Surgery Keratoconus Other: _____

***Please list any known allergies to drugs or medications:** _____

***Do you have airborne allergies?** (Pollen, dust, grass, mold, pet dander, etc.) *Circle one:* Mild Moderate Severe

***Please list any prescription or non-prescription medications you are taking:** _____

Date of your last physical exam: _____ *Date of last **eye** exam: _____

FAMILY HISTORY

- Does anyone in your immediate family (parents, grandparents, siblings) has or had:
- Diabetes Glaucoma
 - Heart disease Retinal Detachment High Blood Pressure Crossed or Lazy Eye Keratoconus
 - Stroke Macular Degeneration Laser Vision Correction Cataracts Other: _____

PAYMENT INFORMATION - Payment for professional services are expected at the time of service. All orders for materials require a minimum 50% deposit with any balance due upon delivery. Our office gladly accepts cash, credit cards, debit cards, and personal checks drawn on local financial institutes.

INSURANCE- We will accept insurance assignment on VISION PLANS and some MEDICAL PLANS; however with the advent of HMO's, PPO's, IPA's and many other options, we cannot accept assignment for all plans or be responsible for knowing about all types of benefits. Therefore, if you have an insurance that we do not bill directly, you will be asked to pay this office and we will provide you with an itemized receipt. Please remember that regardless of insurance coverage or insurance company decisions, each patient is ultimately responsible for all charges incurred. Thank you for your understanding.

PERSONAL HEALTH INFORMATION- I have read and understand my privacy rights with regards to my personal health information.

_____ **Patient** (parent or guardian) **Signature**

_____ **Date**