

WELCOME TO OUR OFFICE



OPTOMETRIC CENTER FOR
FAMILY VISION CARE AND VISION THERAPY
1234 Cherry Street, San Carlos, CA 94070
650.593.1661 www.FamilyVisionCare.org

Last _____ First _____ MI _____
Street _____
City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Sex M F
Home Phone _____ Work/Cell _____
Email Address _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's) Name(s) _____
Spouse (or Parent's) Contact # _____
Patient's SSN _____

What are your major concerns (and/or) needs that you would like addressed today? _____

Any concerns with your contacts or glasses?

Who may we thank for referring you?

If not referred, how did you choose our office?

- Internet: Which Web Site? _____
 Insurance List Saw Sign/Building
 Yellow Pages: Which directory? _____
 Other _____

Insurance Information

Vision Insurance Co. _____
Subscriber Name _____
Subscriber SSN & Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN & Birth Date _____

Do you have a flex spending account? Yes No

This information is confidential and critical to the evaluation of your vision and health.

Patient Medical History

Family Physician _____ City _____
Last Physical Exam Date _____
Pregnant or Nursing Yes No

Any Current Medications: Yes No
List name(s) and purpose, including over the counter, eye drops, vitamins & birth control pills: _____

Allergies to Medications: Yes No List: _____

Have you ever been diagnosed or treated for the following?

- Allergies Diabetes TBI/ Stroke
 Asthma Heart Disease Thyroid
 Arthritis High Blood Pressure
 Cancer Kidney
 Cholesterol Learning /Reading Difficulties
 Other: _____

Patient Eye History

Last Eye Exam Date _____
With Whom _____ Age of Glasses _____
Do you use Sports Goggles or Safety Glasses?
 Yes No

What sports or hobbies do you enjoy? _____

Contact Lens History

If you currently wear contact lenses, please provide as much of the following as possible:

Solution Using _____
Wearing Time _____ (Hrs/Day, Day/wk, etc.)
Brand/ Base Curve _____
Power: Right _____ Left _____

Would you like to try contact lenses that change the color of your eyes? Yes No
Are you dissatisfied with the vision and/or comfort of your contact lenses? Yes No
If you no longer wear contact lenses, why did you discontinue their use? _____

**Financial Policy, Release of Information,
And Assignment of Benefits**

Optometric Center for Family Vision Care and Vision Therapy extends the courtesy of filing to your insurance company. However, insurance coverage is a contract between you and your insurance company, and you are ultimately responsible for the payment of services rendered.

I agree that all co-payments and/or deductible amounts due will be paid at the time services are rendered, unless payment arrangements have been made. I authorize payment of medical benefits directly to Carole Hong, O.D. and Kristina Stasko, O.D. for services rendered and allow the release of any information necessary to obtain payment.

_____ Date
Patient, Parent or Guardian Signature

Family Medical/Eye History (Check all that apply)

Is there a family medical history of:

Please indicate relationship (i.e. grandma, uncle, etc.)

- Blindness _____
- Cataracts _____
- Corneal Problems _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Glaucoma _____
- Lazy Eye / Eye Turn _____
- Macular Degeneration _____
- Retinal Problems _____

Personal Eye History (Check all that apply)

Have you ever been diagnosed or treated for:

- Cataracts Iritis / Uveitis
- Corneal Abrasion Lazy Eye / Eye Turn
- Eye Infection Macular Degeneration
- Eye Injury Retinal Detachment
- Glaucoma Other (i.e., LASIK)

With what you normally wear, do you experience?

- (glasses contacts no correction)
- Far Vision Blur Near Vision Blur Tearing
 - Light Sensitivity Burning/Dryness Itchiness
 - Floater/Spots An Eye Turn Headaches
 - Red Eyes Often Trouble Seeing at Night
 - Flashes of Light Eye Strain/ Fatigue
 - Double Vision Uncomfortable Glasses/Contacts

**Do you.....
(Check box if your answer is yes)**

- ..Have prescription sunglasses?
- ..Prefer not to wear your glasses at times?
- ..Have interest in a "Test Drive" of the latest in contact lenses?
- ..Have interest in a non-surgical approach to vision correction?
- ..Want information on Laser Vision Correction surgery?
- ..Spend time outdoors? (How much?) ___hrs/week
- ..Have only 1 usable pair of prescription glasses?
- ..Want thinner and lighter lenses?
- ..Have symptoms during/ or after computer use?
- ..Want to improve reading/comprehension, learning success or sports performance?
- ..Have family members in need of eye care?
Children's Names & Ages _____

For Students, Please Complete This Section

In order to assist the doctor in evaluating visual skills needed in the learning environment, please grade, and then check all the boxes that apply.

1 - below average 2 - average 3 - advanced
 Reading ___ Spelling ___ Penmanship ___
 Math ___ Writing ___ Physical Ed ___

- Honors Curriculum Doesn't Enjoy reading
 - Regular Classroom Prefers to be Read to
 - Special Education Poor Writing Skills
 - Repeated Grade Short Attention Span
 - Teacher has Concerns about School Performance
 - Poor Reading Comprehension Squints
 - Loses Place when Reading Turns Head
 - Makes Errors when Copying
 - Rubs or Blinks Eyes Excessively
 - Fatigue, Frustrated, or Day Dreams Often
 - Clumsy or Awkward
 - Left and Right Confusion or Reversals
 - Inconsistent or Poor Sports Performance
 - Variable School Performance
 - Hearing, Auditory Processing, or Speech Problem
 - Unusual Sensitivities to Clothing, Taste, Touch, etc
 - Type of Therapy: Occupational Speech Physical Psycho-Educational Other
- More to share in private, Check here