ORANGE PLAZA OPTOMETRY
MEMBER VISION SOURCE NETWORK

Patient Registration and Current Health History

☐New Patient
☐Previous Patient

Today's Date: _____

☐Mr. ☐Mrs. ☐Ms.

☐ Female ☐ Male

First Name: _____ Last Name: _____ Age: _____ Birth Date: _____

Parent/Guardian Name (If patient is Under 18 years of age): _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Patient's Occupation: _____ If Student, Grade: _____

☐Home Phone ☐Cell Phone: (_____) _____ Emergency Contact Phone: (_____) _____

Reason for today Visit: _____

☐PRIVATE PAY

INSURANCE Plan Name: _____
INSURANCE ID: _____
☐Self ☐Spouse ☐Dependent

Policy Holder's Name: _____
Policy Holder's D.O.B: _____
Policy Holder's Last 4 SS: _____

PATIENTS SYMPTOMS
(Check all that apply)

☐ Routine exam
☐ Blurry near vision
☐ Blurry Far vision
☐ Burning eyes
☐ Double Vision
☐ Dry Eyes
☐ Eye Strain/fatigue
☐ Headaches
☐ Droopy Eyelid
☐ Temporary loss of vision
☐ Other _____
☐ Itching eyes
☐ Light Sensitive
☐ Red eyes
☐ Flashes of light
☐ Floating spots
☐ Twitching eyelids
☐ Fluctuating Vision
☐ Watery Eyes
☐ Swollen eyelid

PATIENTS HEALTH HISTORY
(Check all that apply)

☐ None
☐ Allergies
☐ Asthma
☐ Blackouts
☐ Blindness
☐ Cancer
☐ Cataract
☐ Cholesterol
☐ Color Blind
☐ Diabetes
☐ Drug sensitive
☐ Other _____
☐ Glaucoma
☐ Hay fever
☐ Heart Condition
☐ High blood pressure
☐ Lazy eye (Amblyopia)
☐ Migraine
☐ Skin condition
☐ Thyroid condition
☐ Tuberculosis
☐ Strabismus
☐ Macular Degeneration

FAMILY HEALTH HISTORY
(Check all that apply)

☐ None
☐ Allergies
☐ Asthma
☐ Blackouts
☐ Blindness
☐ Cancer
☐ Cataract
☐ Cholesterol
☐ Color Blind
☐ Diabetes
☐ Drug sensitive
☐ Other _____
☐ Glaucoma
☐ Hay fever
☐ Heart Condition
☐ High blood pressure
☐ Lazy eye (Amblyopia)
☐ Migraine
☐ Skin condition
☐ Thyroid condition
☐ Tuberculosis
☐ Strabismus
☐ Macular Degeneration

Last Visit/Physical with you Primary Care Physician (Family Doctor) _____ Doctor Name: _____

Do you smoke, consume alcohol, or use recreational drugs? ☐Yes ☐No If yes, how often? _____

Females: Are you pregnant? ☐Yes ☐No Are you breastfeeding? ☐Yes ☐No

Please list current medication, including eye drops: _____

Allergies to any medications ☐Yes ☐No If yes, please list which medications: _____

Previous eye disease, eye surgery, or eye injury ☐Yes ☐No If yes, please explain: _____

Have you ever worn contact lenses? ☐Yes ☐No If yes, which type? ☐Hard/RGP ☐Soft Brand Name: _____

Date of last eye exam with any
Optometrist or Ophthalmologist: _____ Name of previous Eye Doctor: _____

Patient signature
(Or parent/guardian if patient is under 18 years old) _____ **Date:** _____

I authorize the release of a copy of my medical records, including prescriptions, to co-managing physicians, optical and contact lens dispensaries, upon my request. I understand my prescription will be provided upon completion of the exam and payment of services. I understand my records are kept confidential per HIPPA guidelines and authorize the release of medical records to process my insurance claims. I agree and understand that I am financially responsible for full payment of services/materials that are not covered by my insurance. I understand authorizations obtained at time of service do not guarantee payment. Our Office Policy, only routine follow-up visits are included within 3 months of annual routine exam date; fees will be charged thereafter

For Contact Lens Patients: I understand the risks of contact lens use and take full responsibility for the care of my contacts and the health of my eyes. I understand proper contact lens care and cleaning/insertion/removal. I understand contact lens training is provided and contact lens prescriptions are valid for one year only.

Patient signature
(Or parent/guardian if patient is under 18 years old) _____ **Date:** _____