

YOUR REASON(S) FOR VISITING OUR OFFICE TODAY: (Please check appropriate items)

- | | | |
|--|---|--|
| <input type="checkbox"/> General annual exam (no specific problem) | <input type="checkbox"/> Blurred distance or near vision | <input type="checkbox"/> Eyes water |
| <input type="checkbox"/> Lost or broken eyeglasses | <input type="checkbox"/> Eyes feel tired | <input type="checkbox"/> Eyes itch |
| <input type="checkbox"/> Want new eyeglasses | <input type="checkbox"/> See "spots" or flashes | <input type="checkbox"/> Eyes feel dry |
| <input type="checkbox"/> Want contact lenses | <input type="checkbox"/> Double vision | <input type="checkbox"/> Pain in eyes |
| _____ Soft _____ Hard (RGP) | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Other (please list) _____ |
| _____ Daily _____ Color | <input type="checkbox"/> Headaches | _____ |
| _____ Bifocal Contact Lenses | <input type="checkbox"/> Problems with present contact lenses | _____ |

LIFESTYLE NEEDS: (Please check appropriate items)

- | | |
|---|--|
| <input type="checkbox"/> I spend a lot of time outdoors | <input type="checkbox"/> I have trouble with close work while:
___ Reading ___ Hobbies |
| <input type="checkbox"/> I have trouble seeing at night | ___ Using My Computer ___ Hours/Day |
| <input type="checkbox"/> I am light sensitive, driving in bright sunlight and glare bothers me | <input type="checkbox"/> The Weight/Thickness of my glasses bother me |
| Are you interested in Laser Vision Correction? <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> The Bifocal line bothers me, I have to tilt my head to see |
- List any active sports/hobbies: _____

ABOUT YOUR GENERAL HEALTH - PAST OR PRESENT:

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> "Lazy Eyes" | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> List Medications _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Disorders | <input type="checkbox"/> Allergies to Medication? _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eye Injuries | <input type="checkbox"/> Other: _____ |
- Has anyone in your family (blood relatives) had any of the above conditions? YES NO
If so, what relative? What condition(s)? Please list here (do not check in list above) _____

OFFICE USE Reviewed By: _____ No Changes Date _____

I certify that I have insurance coverage with _____ Name of Insurance Company(ies) and assign directly to _____ Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization: I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____ Name of Doctor or Clinic for any services furnished to me by the provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative _____
Date _____
Relationship to Beneficiary _____

AUTHORIZATIONS

For returning patients only: I certify that my personal information including my address, phone number, health and medical information has not changed since my last eye examination on ____/____/____ (with the exception of: _____) X _____ Date ____/____/____

Whom may we thank for referring you? _____

Employer Name _____
Name of Primary Member _____
Occupation _____
Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Member ID # _____ Birthdate _____
Employer Phone (_____) _____
Address _____ City _____ State _____ Zip Code _____
Home Phone (_____) _____ Cell Phone (_____) _____ E-mail _____
Name _____ Last Name _____ First Name _____ Middle Initial _____
SSN/Patient ID # _____

PATIENT INFORMATION

Welcome to Long Beach Family Optometry – Dr. Justin Prasad, O.D.