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

PATIENT INFORMATION

Name _____ SSN/Patient ID# _____
Last Name First Name Middle Initial

Address _____ City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone (_____) _____ E-mail _____

We are now utilizing E-Communications to confirm your appointment, let you know your glasses or contacts are ready and send information about your eye health. Please check if you would also like to receive text messages. ❒ Yes ❒ No *(All patient information is strictly confidential.)*

Sex ❒ M ❒ F Age____ Birthdate____ /____ /____ ❒ Married ❒ Widowed ❒ Single ❒ Minor ❒ Separated ❒ Divorced ❒ Partnered for ____ years

Occupation _____ How did you hear about us? _____

Name of Primary Member _____ Birthdate____ /____ /____ Member I.D. # _____

Name of Insurance Company(ies) _____ Employer Name _____

AUTHORIZATIONS

Dr. Justin Prasad 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 payments for services and determining insurance benefits or the benefits payable for related services. 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, online and phone payments.

X _____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

For returning patients only: I certify that my personal and insurance information has not changed.

X _____ Date____ /____ /____ **X** _____ Date____ /____ /____

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

❒ General annual exam (no specific problem)
❒ Lost or broken eyeglasses
❒ Want new eyeglasses
❒ Want contact lenses
_____Soft _____Hard (RGP)
_____Daily _____Color
_____Bifocal Contact Lenses

❒ Blurred distance or near vision
❒ Eyes feel tired
❒ See "spots" or flashes
❒ Double vision
❒ Light sensitivity
❒ Headaches
❒ Problems with present contact lenses

❒ Eyes water
❒ Eyes itch
❒ Eyes feel dry
❒ Pain in eyes
❒ Other (please list) _____
_____
_____

LIFESTYLE NEEDS *(Please check appropriate items)*

❒ I spend a lot of time outdoors

❒ I have trouble with glare at night

❒ I am light sensitive, driving in bright sunlight bothers me

❒ The Weight/Thickness of my glasses bother me

❒ I have trouble with close work while:

____Reading ____Using my Smartphone

____Computer ____Desktop ____Laptop ____iPad or E-Reader

____Arts & Crafts

❒ Are you interested in Laser Vision Correction? ❒ Yes ❒ No

List any active sports/hobbies:_____

ABOUT YOUR GENERAL HEALTH - PAST OR PRESENT:

❒ High Blood Pressure
❒ High Cholesterol
❒ Diabetes
❒ Thyroid
❒ Cancer

❒ Respiratory
❒ Glaucoma
❒ Cataracts
❒ Retinal Disorders
❒ Eye Injuries

❒ Eye Surgery
❒ "Lazy Eyes"
❒ List Medications _____
❒ Allergies to Medication?_____
❒ Other:_____

❒ Allergies

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)_____