TARAVAL EYE CARE OPTOMETRY

834 Taraval Street, San Francisco 94116

PERSONAL INFORMATION

Name: _____ Birthdate: _____/_____/_____

If Minor, Parent/Guardian's Name _____

Street Address/City/Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____ Occupation/Employer: _____

SSN: XXX-XX- _____ Driver's License #: _____

How were you referred to our office? _____

Name of Primary Care Doctor: _____ Dr.'s Phone: (_____) _____

Emergency Contact: _____ Phone: (_____) _____

INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient _____

Insured's SSN: XXX – XX - _____

Vision Insurance Plan:
- ☐ Vision Service Plan (VSP)
- ☐ Medical Eye Services (MES)
- ☐ Other (please specify): _____

Medical Health Insurance Company: _____
(please present a copy of your card so that we may bill on your behalf)

EYE AND VISION HISTORY

What is the PRIMARY reason for your visit today? _____

When was your last eye exam? _____

Do you currently wear glasses? ☐ Y ☐ N

Do you wear contact lenses? ☐ Y ☐ N What type? ☐ Soft ☐ Rigid ☐ Disposable ☐ Toric ☐ Bifocal

If you are not a contact lens wearer, are you interested in trying contacts at this time? ☐ Y ☐ N

Have you ever had eye surgery? ☐ Y ☐ N If yes, what type? _____ When? _____

Do you work on a computer? ☐ Y ☐ N If yes, how many hours per day? _____

Do you CURRENTLY experience any of the following?

☐ Itchy Eyes	☐ Tired Eyes	☐ Mucous Discharge	☐ Blurred Vision
☐ Dry Eyes	☐ Eye Strain	☐ Glare/Light Sensitive	☐ Distorted Vision/Halos
☐ Sandy/Gritty Eyes	☐ Frequent Headaches	☐ Double Vision	☐ Floaters or Spots
☐ Burning	☐ Red Eyes	☐ Watery Eyes	☐ Lazy or Turned Eye
☐ Severe Eye Pain			

**** PLEASE COMPLETE OTHER SIDE ****

PERSONAL MEDICAL HISTORY

Are you using any of the following?

☐ Aspirin	☐ Birth Control Pills	☐ Alcohol	☐ Cigarettes
☐ Advil (Ibuprofen)	☐ Blood Pressure Medicine	☐ Marijuana	
☐ Herbs	☐ Vitamins	☐ Cocaine	

Please list any other medications _____

Do you have allergies to any medications? ☐ Y ☐ N Please specify _____

Are you pregnant or nursing? ☐ Y ☐ N

Do you use tobacco products? ☐ Y ☐ N If yes, amount/duration: _____

Do you currently, or have you ever had any problems in the following areas? (If YES, please explain below)

	Y	N
Eyes (Glaucoma, Cataract, Injury, Macular Degeneration, Retinal Detachment)	☐	☐
Ear/Nose/Throat (Sinus Problems, Dry Mouth/ Throat, Hearing Loss)	☐	☐
Cardiovascular (High Blood Pressure, Heart Problems, Vascular Disease)	☐	☐
Respiratory (Asthma, Chronic Bronchitis, Emphysema)	☐	☐
Gastrointestinal (Heartburn, Abdominal Pain, Constipation, Vomiting)	☐	☐
Genitourinary (Genital/Urinary Problems, Kidney/Bladder Problem)	☐	☐
Integumentary (Exzema, Psoriasis)	☐	☐
Musculoskeletal (Rheumatoid Arthritis, Muscle Pain, Joint Pain)	☐	☐
Neurological (Headaches, Migraines, Seizures)	☐	☐
Lymphatic/Hematologic (Anemia, Bleeding Problems)	☐	☐
Endocrine (Thyroid, Diabetes)	☐	☐
Psychiatric (Anxiety, Depression)	☐	☐

Please explain any YES answers: _____

_____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, and/or children) with the following conditions:

	Y	N	?	Relationship		Y	N	?	Relationship
Blindness	☐	☐	☐	_____	Diabetes	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____	Heart Disease	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____	High Blood Pressure	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____	Kidney Disease	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____	Lupus	☐	☐	☐	_____
Rheumatoid Arthritis	☐	☐	☐	_____	Thyroid Disease	☐	☐	☐	_____
Cancer	☐	☐	☐	_____	Other _____	☐	☐	☐	_____

ACKNOWLEDGEMENT OF RECEIPT/SIGNATURE AUTHORIZATION

I certify that the above questions have been accurately answered. I authorize TEC Optometry to release any information pertaining to my eye examination to third party payers and/or health practitioners. I acknowledge that I have received a copy of the HIPAA Notice of Private Practices and I understand how my personal information may be used. I have been informed that my insurance plan may not cover the services provided today or may provide only reduced benefits. In that event, I am responsible to pay for any services not completely covered by insurance.

Signature of Patient (or Responsible Party) _____ Date _____

Thank you for choosing Taraval Eye Care Optometry for your eye care and vision needs!