Patient Information

Date: _____

Patient Name (Legal): _____
First Middle Last

Preferred Name (if different): _____

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

Home Phone: _____ Work Phone: _____ Cell: _____

Gender: _____ Preferred Pronoun: _____

Date of Birth: _____ Age: _____

Social Security Number: _____ Relationship Status: _____

If patient is a minor, name of responsible parent: _____

Race: Ethnicity:

Preferred Language:

Patient's Occupation: _____ Patient's Employer: _____

Whom may we thank for referring you to this office? _____

Vision Insurance: ☐ Yes ☐ No

Primary Vision Insurance: _____

Subscriber Name: _____ Subscriber ID #: _____

Subscriber Date of Birth: _____ Relationship to patient: _____

Secondary Vision Insurance: _____

Subscriber Name: _____ Subscriber ID #: _____

Subscriber Date of Birth: _____ Relationship to patient: _____

Preferred Pharmacy: _____ Location: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARATION:
I hereby authorize the release of any medical information necessary to process my insurance claim and assign to Dr. Esqueda all payments from my insurance provider(s) for services rendered. I understand I will be financially responsible for all charges if my insurance denies payment. I will also be responsible for any remaining charges after my insurance pays. I understand and agree to the above conditions.

HIPAA PRIVACY RIGHTS AND AUTHORIZATION FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION
Federal law requires us to request from you an agreement that we can disclose personal health information, such as your glasses prescription or conditions of your eyes or general health, to authorized parties. These may include such entities as your other doctors, pharmacies, optical labs and your insurance carriers. We have a detailed Notice of Privacy Practices available for a more complete description of our policies if you wish to read it.
Our office will not make available any personal information to any other persons without your specific prior written consent. We will honor any request from you to limit the exchange of information about your health condition if we are able to do so without impairing our ability to provide good medical care. We retain the right to terminate our professional relationship if we disagree with this policy.

Patient Signature: _____

When was your last medical exam? _____ Primary Care Physician: _____

Height: _____ Weight: _____

CURRENT MEDICATIONS

MEDICATION	CONDITION TREATED	DOSAGE

ALLERGIES TO MEDICATIONS

MEDICATION	DATE	REACTION

When was your last eye exam? _____ Were your eyes dilated? Yes / No

Do you wear glasses? ☐ Yes ☐ No How old are your glasses?

Do you wear contact lenses? ☐ Yes ☐ No How old are your contact lenses? _____

PATIENT'S VISUAL SYMPTOMS (check symptoms you are **CURRENTLY** experiencing)

- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Burning, sandy, or gritty eyes
- ☐ Double vision
- ☐ Eye pain or soreness
- ☐ Itchy or watery eyes
- ☐ Light sensitivity or problems with glare
- ☐ Loss of vision and/or side vision
- ☐ Red eyes or eye infections
- ☐ See flashes of light or floaters
- ☐ Other: _____
- ☐ None

PATIENT'S HISTORY (Do you take medications for or have you been **DIAGNOSED** with any of these conditions?)

- ☐ Allergies
- ☐ Arthritis
- ☐ Cancer Type:
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Thyroid
- ☐ Amblyopia – "Lazy eye"
- ☐ Blindness
- ☐ Cataracts
- ☐ Color Vision Deficiency
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disorders
- ☐ Strabismus or Turned Eye
- ☐ Other:

SURGICAL HISTORY (Including Eye Surgery)

YEAR	TYPE OF SURGERY	YEAR	TYPE OF SURGERY

FAMILY HEALTH HISTORY (Has anyone in your family been **DIAGNOSED** with any of these conditions?)

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cataracts
- ☐ Color Vision Deficiency
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Turned Eye
- ☐ Other:

SOCIAL HISTORY

Tobacco Use	Yes/No	If yes, amount per day:	_____
Alcohol Use	Yes/No	If yes, amount per day:	_____
Drug Use	Yes/No	If yes, type:	_____

REVIEW OF SYSTEMS

Do you **CURRENTLY** have any problems in the following areas? If YES, please provide information.

	Yes	No	Details
ALLERGY (allergies or drug hypersensitivities)			
CARDIOVASCULAR (high cholesterol, high blood pressure, irregular heartbeat, etc.)			
CONSTITUTIONAL (General health) (change in appetite, dizziness, fatigue, fever, etc.)			
ENDOCRINE (diabetes, thyroid, temperature intolerance, etc.)			
GASTROINTESTINAL (Acid-reflex, colitis, diarrhea, ulcer, etc.)			
GENITOURINARY (genital, kidney, bladder) (bladder infections, menopause, prostate problems, etc.)			
HEAD (ears, nose, throat) (chronic cough, headaches, hearing loss, sinusitis, etc.)			
HEMATOLOGIC/LYMPHATIC (blood) (anemia, blood disorders, leukemia, bleeding, etc.)			
IMMUNOLOGIC (HIV/AIDS, shingles, chicken pox, TB, etc.)			
INTEGUMENTARY/SKIN (Rosacea, psoriasis, ecxema, acne, etc.)			
MUSCULOSKELETAL (muscles, bones, joints) (arthritis, down's syndrome, osteoporosis, etc.)			
NEUROLOGICAL (Bell's palsy, headaches, epilepsy nystagmus, etc)			
PSYCHIATRIC (Alzheimer's, anxiety, depression, insomnia, etc.)			
RESPIRATORY (asthma, COPD, bronchitis, TB, etc.)			

Reviewed: _____ Date: _____