Sausalito Optometry

Welcome to Our Office

Name: _____Date of Birth_____

Address: _____City _____ State_____ Zip _____

Home Phone: _____Work Phone:_____ Ext. _____Cell Phone: _____

E-mail address_____

Communication Preference: Telephone Email Postal

Employer_____Occupation_____

Vision Insurance Y/N _____ SSN# last 4 digits _____

Date of last eye exam:_____Previous Doctor_____

Spouse or Partner_____ Children_____

How did you hear about our office? _____

Please check any of the following reasons for this exam:

☐ New Glasses ☐ Contact Lenses ☐ Reading Glasses ☐ Computer Glasses ☐ Eye Health Examination ☐ Other_____

Do you have any of the following? If Yes, please check the box

☐ Blurry Vision ☐ Dry Eyes ☐ Flashes/Floaters ☐ Wear Glasses ☐ Wear Contact lenses ☐ Light Sensitivity

☐ Double Vision ☐ Eye Injuries ☐ Eye Surgeries ☐ Tired Eyes ☐ Itchy Eyes

Any eye problems at this time, please explain: _____

Do you have a family history of any of the following? If Yes, please check the box

☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment ☐ High Blood Pressure ☐ Diabetes Cataracts

Please explain any boxes you have checked: _____

Personal Medical Information: Do you have problems with any of these systems? If Yes, please check box:

☐ Gastrointestinal ☐ Nervous System ☐ Mental ☐ Ear/Nose/Throat ☐ Skin ☐ Endocrine (Glands)

☐ Genitourinary ☐ Cardiovascular ☐ Musculoskeletal ☐ Blood/Lymph ☐ Headaches ☐ Allergic/Immunologic

☐ Respiratory ☐ Surgeries (what type and when)_____

Are you in good health? ☐ Yes ☐ No

Do you have any allergies to medications? ☐ No Yes If yes, explain_____

Do you take medications? ☐ Yes ☐ No If yes, please list _____

Name of general physician_____

Please check Yes or No

Do you smoke? ☐ No ☐ Yes How much? _____

Do you drink? ☐ No ☐ Yes How much? _____

I understand that if my insurance eligibility cannot be verified, or if my insurance does not pay the amount due to my account, that I will be financially responsible for payment of all charges incurred for services received from Sausalito Optometry, Inc.

Privacy Notice: This office's privacy practices are in accord with HIPPA regulations. A copy is provided at any visit. Your signature indicates that you have been advised of this information.

Signature_____Date_____

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