WELCOME TO FREMONT OPTOMETRIC GROUP

Personal Information

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
First Name______________________________________
Last Name_______________________________________
Name you prefer to be called_____________________
Address____
City____
State__________________ Zip_____________________
Preferred Phone: ☐ home ☐ work ☐ cell
Home Phone_____________________________________
Work Phone______________________________________
Cell Phone______________________________________
Email____

Today's Date_____________________________________
Date of Birth__________________ Age_____________
Social Security #_________________________________
Gender: ☐ Male ☐ Female
Marital Status____________________________________
Name of Spouse (If applicable)____________________
Name of Children (If applicable)__________________
____
Occupation_______________________________________
Employer____
How did you hear about our office?_______________
____

Vision Insurance Information

Name of Insurance Company for vision care____
Policy Holder Name___________________________ Policy Holder's Date of Birth_____________________
Social Security #_____________________________Name of Employer_____________________________

Secondary Vision Insurance (if applicable)

Name of Insurance Company for vision care____
Policy Holder Name___________________________ Policy Holder's Date of Birth_____________________
Social Security #_____________________________Name of Employer_____________________________

Medical Insurance Information

Name of Insurance Company for medical care____
Policy Holder Name___________________________ Policy Holder's Date of Birth_____________________
Social Security #_____________________________Name of Employer_____________________________

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: By signing this form below, I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Fremont Optometric Group, unless payment is made in full at time of service. I understand that it may be necessary for me to bill my own insurance company directly.

Financial Responsibility

Your signature on this form acknowledges that you, the patient agree to bear full responsibility for all services provided if:

1. It is determined that you are not eligible for insurance coverage.
2. The services are not covered under your benefit plan or we were not made aware of your coverage at the the time of services.
   (Some non-contracted insurance companies have disclaimers stating that they will not guarantee coverage as quoted over the phone at the time of our coverage inquiry).
3. The services have not been referred and/or authorized as required by your health plan.
4. You are seeking services "out of network" with a non-contracted provider.

All charges are due and payable at the time of service unless otherwise specified by an insurance company contracted with us.

I have read and understand the above stated office policies. By signing this form, I agree to comply with these policies.

____ ____
Signature Date

Patient name: ______________________ Today's date: ______________________

Primary care physician: ______________________ Time since last eye exam: ______________________

Clinic name: ______________________ Drug allergies: ______________________

Doctor's phone: ______________________ List current medications: ______________________

Doctor's address: ______________________ ______________________

City: ______________________ ______________________

State & ZIP: ______________________ ______________________

Do you have any of the following symptoms? ☐**NONE**

Blurred distance vision	☐Yes	Headache	☐Yes	Dryness	☐Yes
Blurred near vision	☐Yes	Poor night vision	☐Yes	Redness	☐Yes
Eyestrain	☐Yes	Night glare	☐Yes	Burning	☐Yes
Eye pain	☐Yes	Double vision	☐Yes	Itching	☐Yes
Light sensitivity	☐Yes	Fluctuating vision	☐Yes	Tearing	☐Yes
Floaters or spots	☐Yes	Total Vision Loss	☐Yes	Discharge	☐Yes

Have you had any EYE conditions? ☐**NONE**

Cataract	☐Yes
Macular degeneration	☐Yes
Glaucoma	☐Yes
Diabetic retinopathy	☐Yes
Dry eye	☐Yes
Strabismus (eye turn)	☐Yes
Amblyopia (lazy eye)	☐Yes
Iritis or uveitis	☐Yes
Retinal holes or tears	☐Yes
Retinal detachment	☐Yes
Keratoconus	☐Yes
Trauma	☐Yes
Surgery: ______________________	☐Yes
Other: ______________________	

Are you pregnant? ☐Yes

Are you nursing? ☐Yes

Do you have any HEALTH conditions? ☐**NONE**

Cancer	☐Yes
Developmental disability	☐Yes
Fatigue syndrome	☐Yes
Ear, nose, throat	☐Yes
Neurological (epilepsy/CP/MS)	☐Yes
Psychological (depression/ bipolar/anxiety)	☐Yes
Cardiovascular (blood pressure/stroke)	☐Yes
Respiratory (asthma/COPD)	☐Yes
Gastrointestinal (Crohn's/ulcer)	☐Yes
Genitourinary (kidney/prostate)	☐Yes
Musculoskeletal (gout/arthritis)	☐Yes
Skin (eczema/rosacea/psoriasis)	☐Yes
Diabetes I/II, thyroid, hormone	☐Yes
Blood (anemia/cholesterol)	☐Yes
Autoimmune (RA/Lupus)	☐Yes
Environmental allergies	☐Yes
Other: ______________________	

Please turn over

Do you drink alcohol? ☐No ☐Yes How much/often? ________________

Do you use tobacco? ☐Never ☐Former smoker ☐Current smoker
How much/often? ________________

Do you use recreational drugs? ☐No ☐Yes

Family Health Conditions: ☐**NONE**		Relationship:	**Family Eye Conditions:** ☐**NONE**		Relationship:
Cancer	☐Yes	____________	Cataract	☐Yes	____________
Diabetes Type 1	☐Yes	____________	Macular degeneration	☐Yes	____________
Diabetes Type 2	☐Yes	____________	Glaucoma	☐Yes	____________
Hypertension	☐Yes	____________	Retinal detachment	☐Yes	____________
Hyperthyroid	☐Yes	____________	Amblyopia (lazy eye)	☐Yes	____________
Hypothyroid	☐Yes	____________	Blindness	☐Yes	____________

Do you currently wear glasses? ☐Yes ☐No Since ___________________________

Types of glasses you use: ☐Distance ☐Reading ☐Computer ☐Progressives ☐Bifocal ☐Safety

Do you wear sunglasses? ☐Yes ☐No If yes, are they with prescription lenses? ☐Yes ☐No

Do you currently wear contact lenses?

☐No

Are you interested in trying contact lenses today? ☐Yes ☐No

If so, have you ever tried wearing contacts in the past? ☐Yes ☐No

☐Yes

What **brand** do you wear? ________________________________

How many **hours per day** do you wear them? ________________________________

How many **days per week** do you wear them? ________________________________

How often do you sleep overnight in your contacts? ________________________________

How often do you **replace** your contacts? ________________________________

Which **contact lens solution** do you use? ________________________________