

Welcome to our office. Please fill out this patient history form:

Last Name: _____ First Name: _____ MI: _____ Gender: _____
 Address: _____ City: _____ State: _____ ZIP: _____ SSN: _____
 Date of Birth: _____ Age: _____ Home Phone: _____ Work Phone: _____
 Driver's license number: _____ Parent/Guardian (for minor): _____
 Who recommended or referred you? _____
 Is anyone in your family a patient here? (please list): _____
 Employer/School: _____ Occupation: _____
 Medical Insurance: _____ ID#: _____
 Vision Insurance: _____ ID#: _____

Medical Information

Do you consume alcohol? Yes No If yes, how many drinks per week? _____
 Do you smoke cigarettes? Yes No If yes, how many packs per day? _____
 Are you pregnant or nursing? Yes No

Have you been diagnosed with problems with any of these systems?

Gastrointestinal	Yes	No	Nervous	Yes	No	Endocrine (glands)	Yes	No
Ears/Nose/Throat	Yes	No	Urinary	Yes	No	Blood/Lymph	Yes	No
Cardiovascular	Yes	No	Muscles/Bones	Yes	No	Allergic/Immunologic	Yes	No
Respiratory	Yes	No	Integumentary (skin)	Yes	No	Headaches	Yes	No
Mental	Yes	No	High Blood Pressure	Yes	No			

Please explain: _____

Are you diabetic? Yes No Date of Diabetes Diagnosis: _____

Other health problems: _____

Please list current medication(s): _____

Are you allergic to any medications? Yes No Please list: _____

Personal Eye Information

Do you presently wear glasses? Yes No Contact lenses? Yes No Date of Last Eye Exam: _____

Do you have any eye conditions or problems? Yes No What kind? _____

Have you had any eye injuries or operations? Yes No Please describe: _____

Please circle if you have any of the following:

Macular Degeneration	Yes	No	Glaucoma	Yes	No
Retinal detachment	Yes	No	Cataracts	Yes	No

Family History

Diabetes: Yes No Relation _____ Macular degeneration: Yes No Relation _____

Glaucoma: Yes No Relation _____ Retinal detachment: Yes No Relation _____

Payment is requested when services are rendered.

Method of Payment: Cash Check Credit Card

On accounts referred to collection, reasonable collection fees will be paid by responsible party.

Please sign: _____ Date: _____

ACKNOWLEDGEMENT OF NPP – NOTICE OF PRIVACY PRACTICE

I (print) _____ have read and understand the NPP for Martinez Optometry.

CONTACT LENSES & RELEASE OF INFORMATION

By providing my email address, I consent to receive contact lens and HIPAA protected health information electronically.

Email: _____

I authorize Martinez Optometry to release my protected health information to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____