MARTINEZ OPTOMETRY

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

Last Name: ___________________________ First Name: _________________________ MI: ______ Gender: M F
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: _____________________