

Welcome to Drs. Hall & Szeto Optometry

Last Name		First Name		Office Use
Address		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth
City		Social Security		Occupation
State	Zip	E-Mail Address		
Home Phone ()		Employer Name		
Work Phone ()		Work Address		Zip
Cell Phone ()		Referred By		
Contact Me at: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone		Emergency Contact Name		
Primary Vision Insurance <input type="checkbox"/> VSP <input type="checkbox"/> _____		Contact Phone ()		
Are you the primary member of your insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No then: Name of Primary Insured</i> _____				

What is the main reason for today's eye examination? _____

Are you obtaining, renewing, or updating your contact lens prescription for this year? Yes No *I understand that my CL prescription will expire.*

Please Note: Contact Lens Services are not included in the annual exam fees. The contact lens exam is a separate exam for ensuring proper fit of your contacts and evaluating your vision with the contacts. Additional time and fees (~\$50 to \$150) will be required.

Date of Last Eye Examination? _____

Do you wear glasses? No Yes If yes, age of current eyeglasses? _____
 Do you wear contact lenses? No Yes If yes, what type/brand/power? _____
 Do you work with computers No Yes If yes, what is the distance from your eyes to the computer monitor? _____

Please list any hobbies or activities that may require special correction, i.e. piano, racquetball, aviation, golf, etc....

Please check if you have any of the following conditions:

- | | | | |
|-------------------------------------|---|------------------------------------|--|
| <input type="checkbox"/> eyestrain | <input type="checkbox"/> floaters | <input type="checkbox"/> eye pain | <input type="checkbox"/> eye disease (explain) _____ |
| <input type="checkbox"/> dry eyes | <input type="checkbox"/> flashes of light | <input type="checkbox"/> cataracts | <input type="checkbox"/> eye injury (explain) _____ |
| <input type="checkbox"/> itchy eyes | <input type="checkbox"/> double vision | <input type="checkbox"/> glaucoma | <input type="checkbox"/> eye surgery (explain) _____ |
| <input type="checkbox"/> red eyes | <input type="checkbox"/> macular degeneration | <input type="checkbox"/> lazy eye | <input type="checkbox"/> eye infection (explain) _____ |

Any blood relatives with Glaucoma? No Yes (who?) _____
 Retinal Disease? No Yes (who?) _____

Have you had any operations? No Yes Kind? _____

Are you pregnant or nursing? No Yes If yes, how many months? _____

If you smoke, how often? No Yes _____ Recreational Drug or alcohol use? No Yes _____

Are you being treated for any medical or eye condition(s)? No Yes Please List _____

Please list any medications or drugs that you are currently taking and for what purpose: None

<i>Medication Name</i>	<i>Dosage</i>	<i>Condition Being Treated</i>

Please list allergies or sensitivities to any drugs: Yes _____ No Known Drug Allergies

Please check below if you have a history of medical problems with any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Skin | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Cardiovascular/ Blood Pressure | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Endocrine/ Thyroid/ Diabetes | <input type="checkbox"/> Neurological / Brain | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Immunologic | <input type="checkbox"/> Respiratory / Asthma | |

1. Protected Health Information (HIPAA Disclosure)

I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received and read the Notice of Privacy Practices from Drs. Hall & Szeto Optometry.

2. Insurance Signature on File

I certify that the information given by me in applying for insurance is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and I authorize payment of these benefits directly to Drs Hall & Szeto Optometry on my behalf. If I have other health insurance coverage my signature authorizes release of the above medical information to the insurer or agency, and authorizes my doctor to act as my agent as above.

X _____

Date _____ / _____ / _____

Patient or Guardian Signature