South East Eye Family Vision Center Patient History Form

Dr. Miri Park, Optometrist (Confidential by law)

Welcome to our office.

Please take a few minutes to provide us with the following information. It will be very helpful for your eye-care.

Last Name:____________________ First Name:____________________ Middle Initial:_____

Home #:__________________ Work #:___________________ Cell #:____________________

Email: _________________________________ Last 4 digits of Social Security #:__________

Date of Birth:____/____/_____ Age:______ ☐M ☐F Occupation:_______________________

School:__________________________ Grade:_____ Teacher:_________________________

Home Address:____

City/Town:________________________________ State:________ Zip code:_____________

Hobbies:____

Primary reason for today's exam:

☐Routine Eye Exam ☐Contact Lens Eye Exam ☐Other:_________________________

Date of last exam____/____/____ Where________________ By whom:__________________

How did you hear about our office ____

Do you currently wear glasses ______ If yes: For what purpose ☐Far ☐Near ☐Both

For how many years? _____ How old are the glasses? _____ yrs. Any problems: _________

____

Do you currently wear contact lenses ______ If yes, please answer the following questions:

Type of contact lens: ☐Soft ☐RGP ☐Disposable ☐Toric ☐Monovision ☐Bifocal

Worn for ______ yrs. Wear ______ hrs/day ______ days/week

Clean them with ______________________________ contact lens solution

Method of wear: ☐Daily wear ☐Extended wear ☐Flexible wear

Have you had: Any eye injuries/surgeries: ____ Sudden loss of vision____ Double vision:___

Do you use a computer:______ if yes, ________ hrs. per day

Do you have any eye discomfort from it? ____

When was your last physical exam? ____/____/____

Primary care physician/ Pediatrician: ____

Are you currently under the care of any physician or ophthalmologist for any reason? Y / N

If yes, please briefly explain: ____

Please list any medications you are taking _______________________________________

____

Are you allergic to any eye drops, ointments, medications, or have any known allergies? Y / N

If yes please list them____

Family History of Glaucoma: YES NO

Family History Macular Degeneration: YES NO

If yes, who? ____

Pre-appointment:: Please indicate if the same time and day is suitable for your next yearly exam. We will check with you one month in advance to confirm your availability, and adjust accordingly: YES / N0

Medical Information and Payment Authorization:

I request that payment of authorized medical benefits be made on my behalf to South East Eye Health Center, Inc. for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any other insurer, any information needed to determine these benefits payable for related services. A copy or system generated printout of this release will be as valid as the original form. Although I have indicated that I am covered by the above health insurer(s), I acknowledge and agree that I am personally responsible for any co-payments and/or deductibles associated with the services I receive which are not covered by my insurance, and that I will be personally liable for all charges associated with the services I receive if for any reason it is determined that my insurance is not obligated to pay for said services or that I am not covered by the insurance identified.

I am responsible for presenting my insurance card to SEE Health Center if my insurance changes to a new plan. I am responsible for notifying SEE Health Center of the change at the time of visit. Without an insurance card I understand I have 15 days to provide SEE with the insurance information, or I will be personally responsible for payment in full for service received and or products purchased.

I understand that it is my responsibility to call my Primary care Provider to request a referral authorization if the reason for my appointment requires one. I agree to call my doctor with this request prior to the visit or within 24 hours after the visit. I agree to be responsible for payment of services if a referral is not granted by my primary care provider.

Signature of Patient:______________________________________ Date:______________