WELCOME TO VISION QUEST OPTOMETRY

LAST NAME	FIRST NAME	M.I.	SEX M/F	BIRTH DATE / /
ADDRESS	CITY		STATE	ZIP

TELEPHONE: CELL ( )
HOME ( )
WORK ( )

EMAIL:

REFERRED BY: RELATIVE/ FRIEND _____
MAIL INS. LIST WALK IN YELLOW PAGES

SOCIAL SECURITY #: DRIVER'S LICENSE #:

OCCUPATION: EMPLOYER'S NAME:

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION NECESSARY TO PROCESS THIS INSURANCE CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY SERVICES OR MATERIALS THAT ARE NOT COVERED BY MY INSURANCE COMPANY.

SIGNATURE _____ DATE _____

INSURANCE

POLICYHOLDER'S NAME: _____
POLICYHOLDER'S DATE OF BIRTH: _____
POLICYHOLDER'S SOCIAL SECURITY #: _____
POLICYHOLDER'S ID #: _____

PLEASE CIRCLE VISION INSURANCE:
VSP EYEMED MES OPTUM HEALTH SAFEGUARD
OTHER: _____
MEDI-CAL: ID#: _____
MEDI-CARE ID#: _____

MEDICAL INFORMATION

Date of Last Eye Exam: _____ Dilated? Yes / No From Doctor: _____

Do you wear **glasses**? Yes / No
If yes, how old is your present pair? _____

Do you have reading/computer glasses? Yes / No
Do you have bifocals/progressive lenses? Yes / No
Do you have prescription sunglasses? Yes / No
Do you have safety glasses? Yes / No

Do you wear **contact lenses**? Yes / No
If yes, how old is your present pair? _____

Type of contact lenses (Please circle):
RGP Soft Toric Multifocal Monovision

If you do not currently wear contacts, have you ever tried them? Yes / No When? _____

Do you have any allergies to medications? Yes / No If yes, please list _____

Please list any medications you take (including over the counter medications): _____

Please list all major injuries, surgeries, and/or hospitalizations you have had: _____

SOCIAL HISTORY

Do you drive? Yes / No If yes, do you have visual difficulty when driving? Yes / No If yes, please describe:

Do you use tobacco products? Yes / No If yes, type/ amount/ how long: _____
Do you drink alcohol? Yes / No If yes, type/ amount/ how long: _____
Do you work with a computer? Yes / No If yes, how many hours per day? _____

HOBBIES AND ACTIVITIES

What sports or hobbies do you enjoy? _____

**** PLEASE TURN OVER ****

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/ CONDITION	NO	YES	
Blindness	☐	☐	
Cataract	☐	☐	
Crossed Eyes	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart disease	☐	☐	
High blood pressure	☐	☐	
Kidney disease	☐	☐	
Lupus	☐	☐	
Thyroid disease	☐	☐	
Other _____	☐	☐	

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES
NEUROLOGICAL		
Headaches/ Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of vision	☐	☐
Blurred vision	☐	☐
Distorted vision/ halos	☐	☐
Floaters	☐	☐
Flashes	☐	☐
Loss of side vision	☐	☐
Double vision	☐	☐
Dryness	☐	☐
Mucous discharge	☐	☐
Redness	☐	☐
Itching	☐	☐
Burning	☐	☐
Lazy eye	☐	☐
Glare/ Light sensitivity	☐	☐
Eye pain or soreness	☐	☐
Chronic infection of eye/lid (sties)	☐	☐
EARS, NOSE, THROAT, MOUTH		
Allergies/ Hay fever	☐	☐
Chronic cough	☐	☐

	NO	YES
LYMPHATIC/ HEMATOLOGIC		
Anemia	☐	☐
Bleeding problems	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/ CARDIOVASCULAR		
Diabetes	☐	☐
Vascular disease	☐	☐
High blood pressure	☐	☐
BONES/ MUSCLES		
Joint Pain	☐	☐
Arthritis	☐	☐
Muscle pain	☐	☐
PSYCHIATRIC	☐	☐

If you answered YES to any of the above or have conditions not listed, please explain & list medications: _____

Receipt of Notice of Privacy Policies & Consent Form

Vision Quest Optometry
937 W. Huntington Drive
Monrovia, CA 91016

Tel: (626) 357-0408
Fax: (626) 357-6768
E-mail: visionquestoptometry@yahoo.com

Patient Name:_____

Patient Number:_____ Patient Phone Number:_____

Patient Address:_____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. 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 the *Notice of Privacy Practices* from Vision Quest Optometry.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority:_____