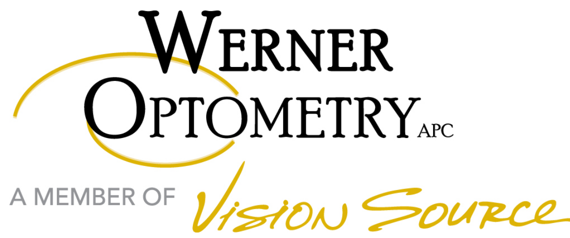

□Dr. □ Mr. □ Mrs. □Ms. □Miss
□ Male □ Female
□Single □Divorced □Married □Widowed
Date of Birth _____/_____/_____

Last Name______________________________ **First Name**______________________ MI______

Address______________________________ **City**__________________ **State**______________ **Zip**________

Home # (______)____________________ **Work #** (______)____________________ **Mobile #** (______)____________________ □ Do not text

Employer________________________ Occupation________________________________ **Prefered communication:** □Email □Phone □Postal

SSN_______-______-_______ **How were your referred to our office**?____

Pref Lang.: □Eng □Other____________ **Race**: □White □AA □Hisp. □Asian □Native Am. □Other____________ **Ethnicity**: □Non-Hisp. □Hispanic

E-MAIL: You will receive appointment reminders, order notifications, yearly recalls, eye care news, and special promotions. You may opt out at any time.

Vision Insurance: □ None □VSP □Tricare □Davis □MES □Medi-Cal □Other__________________

Medical Insurance: □Blue Cross / Shield □Pacificare □Tricare □Cigna □Aetna □Medicare □ Medi-Cal □Other__________________

Member____ **Relation**____________ **DOB** ____/_____/_____ **ID / SSN** ________________

Member____ **Relation**____________ **DOB** ____/_____/_____ **ID / SSN** ________________

FAMILY MEMBERS

	Name	Relation	DOB	Current patient at our office?
1.		/	/	YES / NO
2.		/	/	YES / NO
3.		/	/	YES / NO
4.		/	/	YES / NO
5.		/	/	YES / NO

Payments and Co-Payments All required payments, co-payments, deductibles, and other out-of-pocket expenses are due in full at the time services are rendered or materials are provided, unless specific financial agreements have been made prior to your scheduled appointment. The office accepts VISA, Master Card, debit cards and personal checks with proper identification. All personal checks returned for any reason are subject to a $25 service charge without exception. In the event of nonpayment, the cost of collection and or court costs and reasonable legal fees is the responsibility of the patient.

Vision Plan and Insurance Benefits It is your responsibility to understand the nature of your vision plan and insurance benefits prior to your scheduled appointment. The employees of WERNER OPTOMETRY APC will, to the best of their knowledge and understanding, help answer any questions you may have regarding your vision plan and insurance benefits; however, no guarantee of accuracy regarding eligibility, coverage, or benefit information can be made by anyone other than your vision plan or insurance carrier directly.

Assignment of Benefits I authorize assignment of vision plan and insurance benefits to WERNER OPTOMETRY APC for the purpose of determining eligibility, benefits, and collecting for all services rendered and materials provided. In addition, I authorize WERNER OPTOMETRY APC and any of its employees to furnish information concerning my present condition to insurance companies and referring doctors as deemed necessary.

Misses, Broken & Cancelled Appointments If a scheduled appointment time is missed, broken, or cancelled for any reason without 48 hours notice, a fee of $35 may be assessed to your account. Please notify the office at least 48 hours in advance if you are unable to keep your appointment.

HIPPA Compliancy I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPPA) for this office. I have read and understood the terms and conditions outlined above, and I hereby certify that all of the information provided is true and accurate to the best of my knowledge and understanding.

Signature:____ **Date:**__________________________

Primary Care Physician (or name of Clinic)____**Dr.'s Phone #** (____)__________________

Please complete the following Medical History for yourself and your family as thoroughly as possible. Many medical conditions may involve the eyes even though it may seem unlikely. Many medications can also have effects on your eyes so please list any and all medications you are currently taking.

Are you pregnant and / or Nursing? □No □Yes…If yes, how many weeks / months along are you?______________________________

Date of last Physical:___________________________ **Date of last Eye Exam (here or elsewhere)**__________________________________

HEALTH HISTORY:	Self Y	Self N	Family History *Relationship to you*		Self Y	Self N	Family History *Relationship to you*
Integumentary (Skin)	□	□	________________	High Blood Pressure	□	□	________________
Headaches	□	□	________________	Heart Disease	□	□	________________
Migrianes	□	□	________________	Elevated Cholesterol	□	□	________________
Ears, Nose, Mouth, Throat	□	□	________________	Gastrointestinal	□	□	________________
Arthritis	□	□	________________	Kidney Disease	□	□	________________
Asthma / Lung Disease	□	□	________________	Lupus	□	□	________________
Cancer	□	□	________________	Thyroid Disorder	□	□	________________
Diabetes Type I	□	□	________________	Psychiatric	□	□	________________
Diabetes Type II	□	□	________________	Other	□	□	________________

OCULAR HISTORY:	Self Y	Self N	Family History *Relationship to you*		Self Y	Self N	Family History *Relationship to you*
Glaucoma	□	□	________________	Eye Infections	□	□	________________
Macular Degeneration	□	□	________________	Blindness	□	□	________________
Cataracts	□	□	________________	Crossed Eyes	□	□	________________
Retinal	□	□	________________	Lazy Eyes	□	□	________________
Optic Nerve Disease	□	□	________________	Drooping Eyelid	□	□	________________
Eye Injury	□	□	________________	Other	□	□	________________

Medication Allergies: □None □Penicillin □Sulfa drugs □Other____

List any Medications you Currently take (including oral contraceptives, OTC medications, aspirin, and home remedies) □None

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

List all major injuries, surgeries, hospitalizations you have had (approx date) *including* EYE injuries / surgery: LASIK/PRK, Cataract etc.
□None ____

SOCIAL HISTORY

Please list hobbies you enjoy

____

Do you drink alcohol? □No □Yes How often? □Social use □1-2 drink daily □Dependent □Other ______________________

Do you use tobacco product? □No □Former user □Yes How often? □Less than 1pk day □1-2pk day □More than 2pk / day

Do you use recreational drugs? □No □Recreational use □Chemical dependence Type:_______________

Have you ever been exposed to or infected with ?

STD's □No □Yes _____________________ Blood Transfusion □No □Yes

Do you wear glasses? □No □Yes If yes, how old are your current pairs of glasses? ______________________________

Do you wear contact lenses? □No □Yes Type of lens: □Soft □Toric (for astigmatism) □Gas Permeable (hard) □Multifocal / Monovision

How often do you replace your lenses? □Daily □2 weeks □Monthly □Annual □Other_______________

Do you sleep in your lenses? □No □Yes **What is the brand of contact lens worn?**_________________________

What solution do you use? □Optifree Replenish / Pure Moist □BioTrue □Renu □Other__________________________

Reason for your visit today?

□Check eye health	□Distance Blur	□Near Blur	□Computer Blur / Fatigue	□Night vision blur
□Headaches	□Eyestrain	□Burning	□Watering	□Itching
□Pressure around eyes	□Dry / Sandy / Gritty feeling	□Tired eyes	□Computer Vision fatigue	□Eye pain
□Red eyes	□Flashes / Floaters	□Double vision	□Loss of side vision	□Light sensitivity

□Other (describe)____