Vacaville Optometric Vision Center

Thank you for choosing our office. In order to serve you properly, we will need the following information. Some information is required by insurance companies. All information will be strictly confidential. (Please print)

Date_____

1. PATIENT INFORMATION

Last Name_____

First Name _____MI_____

Address_____

City_____

State_____ Zip Code_____

Date of Birth_____ Sex M F

Home Phone #_____

Daytime Phone #_____

Cell Phone # _____

Email _____

Communication Preference - Home # Day Time # Cell #

Employment Status: Full-time Part-time Not Employed
Student Retired

Employer_____

Occupation_____

Marital Status: Single Married Divorced Widowed

Preferred Language: English Spanish Other_____

Race: Am. Indian Asian Black/African Am.
Hispanic White Pacific Islander
Other

Referred By_____

2. VISION INSURANCE INFORMATION

Name of Vision Insurance:

VSP MES MEDICARE TRIWEST OTHER

Name of Subscriber or Insured Person_____

Subscriber or Insured Persons ID #_____

(ID #s may be the last 4 digits of insured person's SS # **or** a unique ID #)

3. SUBSCRIBER OR INSURED PERSON'S INFORMATION

IF DIFFERENT THAN SECTION 1 PATIENT INFORMATION – LOCATED ON THE LEFT SIDE OF THIS PAGE

Last Name_____

First Name _____MI_____

Relationship To Patient_____

Address_____

City_____

State_____ Zip Code_____

Home Phone_____

Work Phone_____

Cell Phone_____

Date of Birth_____ Sex M F

Employer_____

Occupation _____

4. ADDITIONAL OR SECONDARY VISION INSURANCE

Name of Insurance:

VSP MES MEDICARE TRIWEST OTHER

Name of Insured Person _____

Insured Persons Date of Birth_____

Relationship to Insured_____

ID #_____

Other family members who have been seen in our office

Names:

Please Complete Both Sides

5. MEDICAL INSURANCE INFORMATION

Name of Medical Insurance Plan_____

Health Insurance ID # or Medical Record #

Name of Primary Care Physician (first and last name)

Primary Care Facility Kaiser Sutter
UC Davis NorthBay
DGMC Other

Name of Other Physicians & Specialty

Date of Last Eye Examination If Not at Our Office

6. REASON FOR YOUR VISIT (Please circle all that apply)

Blurry Distance Vision Blurry Near Vision
Annual Checkup Dry Eyes Head Aches
Itchy Eyes Need Contacts Need Glasses
Pain in Eyes Other

7. MEDICAL HISTORY (please list all medical conditions)

Cancer	Y	N	Other
Cholesterol	Y	N	
Diabetes	Y	N	
High Blood Pressure	Y	N	
Thyroid	Y	N	

8. MEDICATIONS (Please list all medications you are taking including over the counter)

Please list all medication to which you are allergic

9. EYE HEALTH HISTORY

	Yourself		Family Members		Relationship
Cataracts	Y	N	Y	N	_____
Detached Retina	Y	N	Y	N	_____
Dry Eye	Y	N	Y	N	_____
Flashes/Floaters	Y	N	Y	N	_____
Glaucoma	Y	N	Y	N	_____
Macular Degeneration	Y	N	Y	N	_____

Other

10. EYE SURGERY

Right Eye Cataract Cornea LASIK Retina Date

Left Eye Cataract Cornea LASIK Retina Date

Other

Do You Wear Glasses Y N

Do You Wear Contact Lenses Y N

If Yes, What Type Soft Rigid Toric

How Often Do You Replace Your Contact Lenses?

Weekly Bi-weekly Monthly Bi-monthly

Other_____

11. SOCIAL HISTORY

Tobacco Use Y N Frequency_____

Alcohol Use Y N Frequency _____

Hobbies

I_____ Do hereby acknowledge receipt of a copy of the Notice of Privacy Practice, Policies, and Procedures. This signature also serves as the insurance signature on file.

_____

Signature Date

In the event this request is made by the individual's personal representative:

_____

Signature of Personal Representative Date

_____

Legal Authority of Personal Representative

Please Complete Both Sides