FOCAL POINT OPTOMETRY

Your Vision Source!®

☐ Mr. ☐ Mrs. *Alvin Arellano, OD* *Aimee Noll, OD*
☐ Ms. ☐ Dr. ☐ Male

Name:______________________________ ☐ Female Date of Birth:__________ Age:______
Last First M.I.

Address:______________________________ City:______________ State:______ Zip:__________

Phone: (______)__________ Alt. Phone: (_____)__________ SSN:_____-____-_____ DL #__________
Please circle one Home/Cell/Work Please circle one Home/Cell/Work

Email:______________________________ Marital Status:______________ Student: __________

Employer:______________________________ Occupation:______________________________

Insurance Provider:________________________ Primary Member:________________________

Primary Member DOB:__________ Primary Member SSN:______________ Referred by: __________

I, the undersigned, directly assign to Focal Point Optometry and its associates, all benefits payable by insurance carriers and/or vision plans for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor/s to release any information necessary to any insurance company in order to secure payment of benefits, or for audit purposes. I authorize the use of this signature on all my insurance claim submissions.

Signature of Patient/Guardian ______________________________ Date:__________________

Medical Information

How is your general health? ______________________________

Do you have problems with any of these symptoms? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Allergic/immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain ______________________________

Diabetes Yes/No Type______________________ Date of diagnosis ______________

Allergies to medication? Yes/No Which? ______________ Reactions? ______________

Other health problems ______________________________

Current medication(s) ______________________________ Check if none ☐

Have you had any operations? Yes/No Kind?______________________ When?__________

Name of family doctor______________ Date of last visit __________ Date of last tetanus shot __________

Family History

High blood pressure	Yes/No	Relation __________	Macular degeneration	Yes/No	Relation __________
Diabetes	Yes/No	Relation __________	Retinal detachment	Yes/No	Relation __________
Glaucoma	Yes/No	Relation __________	Cataracts	Yes/No	Relation __________

Personal Eye Information

Age of Present Glasses: __________ Date of Last Eye Exam: __________ Date of last Dilation: ________

Do you have any eye conditions or problems? Yes/No What kind? ______________________

Have you had any eye operations? Yes/No Type______________________ Date ______________

Have you had an eye injury? Yes/No Kind______________________ Date ______________

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type __________

Additional information ______________________________

The information I have provided above is accurate and complete to the best of my knowledge

X____ Date:________________________________