CANYON LAKE OPTOMETRY

31722 Railroad Canyon Road • Canyon Lake, CA 92587
(951) 244-4444 • FAX (951) 244-1414

PATIENT INFORMATION

PLEASE PRINT - COMPLETE ALL INFORMATION

HOME PHONE _____
WORK PHONE _____
PATIENT'S NAME _____ CELL PHONE _____
(LAST) (FIRST)
ADDRESS _____
(MAILING) CITY STATE ZIP
DATE OF BIRTH _____ AGE _____ MALE ___ FEMALE ___ SOCIAL SECURITY # _____

HOW WERE YOU REFERRED TO OUR OFFICE? TELEPHONE BOOK _____ INSURANCE REFERRAL _____

WALK IN ___ FRIEND/RELATIVE _____ OTHER _____

DATE OF YOUR LAST EXAM _____ GLASSES/CONTACTS _____ DOCTOR _____

WHAT IS YOUR OCCUPATION? _____

PERSON RESPONSIBLE FOR FINANCIAL PAYMENT OF THIS ACCOUNT

NAME _____ EMPLOYER _____ WORK PHONE _____

SOCIAL SECURITY # _____ D.O.B. _____ HOME PHONE _____

ADDRESS (IF DIFFERENT THAN PATIENTS) _____

DO YOU HAVE A VISION PLAN? YES _____ NO _____ POLICY/GROUP NUMBER _____

NAME OF INSURANCE PLAN _____

INSURANCE ADDRESS _____

EMERGENCY CONTACT - RELATIVE OR FRIEND

NAME _____ RELATIONSHIP _____ PHONE _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

MEDICAL HISTORY

MEDICAL DOCTOR'S NAME _____

LIST CURRENT MEDICATIONS (INCLUDING EYE MEDICATIONS): _____

_____

ANY PRESENT ILLNESS _____ ANY PAST SURGERIES _____

ANY KNOWN EYE DISEASE _____ EYE INJURY OR SURGERY _____

ANY ALLERGIES TO MEDICINE _____

CONTINUED ON REVERSE SIDE

ARE YOU INTERESTED IN LASER SURGERY? YES _____ NO _____

IS THERE A FAMILY HISTORY OF (CHECK ALL THAT APPLY):

__CATARACTS __GLAUCOMA __DIABETES __HIGH BLOOD PRESSURE

__COLOR BLINDNESS __BLINDNESS OR POOR NIGHT VISION __CROSSED EYES

__ANY EYE DISEASE (explain) _____

IS THIS EXAMINATION ESPECIALLY FOR?

CONTACT LENSES_____ GLASSES_____ VISION THERAPY_____ OTHER_____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

READING_____STUDYING_____SEWING_____CRAFTS_____MACHINE OPERATION_____

HOME WORKSHOP_____INSTRUMENT_____PIANO_____CARD PLAYING_____TV_____FISHING_____

GOLF_____TENNIS_____RACQUETBALL_____SWIMMING_____TEAM SPORT_____

COMPUTER/TYPEWRITER USE_____ OTHER_____

DO YOU HAVE ANY SPECIAL LENS INTERESTS:

COMPUTER USE_____SUNGLASSES_____SPORT GLASSES_____NO LINE BIFOCALS_____

SAFETY GLASSES_____OTHER_____

PLEASE CHECK THE SYMPTOMS YOU(OR YOUR CHILD) ARE EXPERIENCING:

HEADACHES_____BLURRING_____SQUINTING_____LOSS OF ATTENTION_____EYE DISCOMFORT_____

POOR COMPREHENSION/READER_____ HOLDS READING CLOSE_____EYES TEAR EXCESSIVELY_____

REDDENED EYES OR LIDS_____ SEES DOUBLE _____ MAKES COPYING ERRORS _____

BLUR WITH NEAR TASKS _____AVOIDS NEAR TASKS _____ LIGHT SENSITIVE_____

PAYMENT IS EXPECTED AT TIME SERVICES ARE PROVIDED
WE ACCEPT CASH - CHECK - MASTERCARD/VISA
A 50% DEPOSIT IS REQUIRED ON ALL MATERIALS ORDERED
BALANCES ARE DUE AT THE TIME MATERIALS ARE RECEIVED

I HEREBY AUTHORIZE PAYMENT TO CANYON LAKE OPTOMETRY FOR ALL BENEFITS NOW DUE OR BECOMING DUE UNDER MY MEDICARE AND/OR OTHER GROUP INSURANCE POLICY FOR THE SERVICES THAT HAVE BEEN RENDERED AND I HEREBY DIRECT SAID AGENCY/COMPANY TO PAY SUCH BENEFITS DIRECTLY TO CANYON LAKE OPTOMETRY. I UNDERSTAND THAT I AM RESPONSIBLE TO THE ABOVE NAMED ENTITIES FOR ALL CHARGES NOT COVERED BY ASSIGNMENT OF MY INSURANCE.

DATE_____SIGNATURE_____
(PATIENT/PARENT OR GUARDIAN)

I AUTHORIZE THE RELEASE OF MY OR MY CHILD'S MEDICAL RECORDS AS DEEMED NECESSARY BY THE STAFF OF CANYON LAKE OPTOMETRY TO A MEDICAL PROVIDER OR ON THE REQUEST FROM A MEDICAL PROVIDER. I HEREBY ACKNOWLEDGE RECEIPT OF A COPY OF CL PATIENT HEALTH INFORMATION PRIVACY POLICY.

DATE_____SIGNATURE_____
(PATIENT/PARENT OR GUARDIAN)