

CITY CONTACTS OPTOMETRY

Vincent P. Penza, O.D.

Katherine H. Morioka, O.D.

PATIENT INFORMATION

Name (Last, First, Middle Initial)		Date	
Address		City, State, ZIP	
Phone: (H)	(W)	ext.	(Cell)
Email Address			
Social Security #	Driver's License #	Birthdate	Age
Occupation		Employer	
How did you hear about our Office?	<input type="checkbox"/> Referred By: _____ Relationship: _____ <input type="checkbox"/> Insurance <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other: _____		

ACCOUNT RESPONSIBLE (Parent/Insured Party)

If the patient is the account responsible, you may skip this portion.

Name of Acct. Responsible		Relationship to Patient	
Phone: (H)	(W)	ext.	Is the account responsible a patient here? <input type="checkbox"/> Y <input type="checkbox"/> N
Social Security #	Birthdate	Employer	

INSURANCE INFORMATION (**Please give card to front desk at Check-In)

VISION: Name of Insurance: _____ Name of Insured: _____	MEDICAL: Name of Insurance: _____ Insurance Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> OTHER _____ Name of Insured: _____
--	--

OCULAR HISTORY

Main Reason For Today's Visit: Exam Glasses Contact Lenses Lasik Evaluation Medical Visit Other

Please check if you are experiencing any of the following:

<input type="checkbox"/> Burning	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Headaches	<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Floaters/Flashes
<input type="checkbox"/> Distance Blur	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Itchiness	<input type="checkbox"/> Redness	<input type="checkbox"/> Bumps In/Around Eye

Special Visual Tasks/Hobbies/Sports: _____

Date of your Last Eye Exam? _____ Doctor's Name: _____

GLASSES: <table style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>Do you currently wear Glasses?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>If so, do you wear Prescription Sunglasses?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>How old is your current pair of glasses?</td> <td colspan="2" style="text-align: center;">_____ yr(s)</td> </tr> <tr> <td>Do you work at a computer monitor?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Do you need safety glasses at work?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		YES	NO	Do you currently wear Glasses?	<input type="checkbox"/>	<input type="checkbox"/>	If so, do you wear Prescription Sunglasses?	<input type="checkbox"/>	<input type="checkbox"/>	How old is your current pair of glasses?	_____ yr(s)		Do you work at a computer monitor?	<input type="checkbox"/>	<input type="checkbox"/>	Do you need safety glasses at work?	<input type="checkbox"/>	<input type="checkbox"/>	CONTACT LENSES: Have you ever worn Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what type? BRAND _____ <i>Circle one:</i> Daily Soft EW Soft Disposable Hard Gas Permeable When was the last time you wore Contacts? _____ Are your Contact Lenses comfortable? <input type="checkbox"/> Yes <input type="checkbox"/> No What disinfection system do you use? _____ Where do you buy your Contacts? _____ <div style="text-align: right;">Monovision? <input type="checkbox"/> Yes <input type="checkbox"/> No</div>
	YES	NO																	
Do you currently wear Glasses?	<input type="checkbox"/>	<input type="checkbox"/>																	
If so, do you wear Prescription Sunglasses?	<input type="checkbox"/>	<input type="checkbox"/>																	
How old is your current pair of glasses?	_____ yr(s)																		
Do you work at a computer monitor?	<input type="checkbox"/>	<input type="checkbox"/>																	
Do you need safety glasses at work?	<input type="checkbox"/>	<input type="checkbox"/>																	

Would you like information about Laser Refractive Surgery? Yes No

CANCELLATION POLICY

I, _____, acknowledge that City Contacts Optometry requires **24-hour notice** for any rescheduling or cancellation of an appointment. If for any reason I should not give appropriate notice, I understand that I will be charged a No-Show fee.

Patient Signature _____ Date _____

******COMPLETE BACK PORTION******

