Complete form, print, and bring to appointment

Pacific Optometry
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PATIENT REGISTRATION FORM

Last _____, First _____ MI _____
Address _____City_____ State___Zip _____
Home No. (_____)_____ Work No. (_____)_____
Cell No. (_____)_____ Email _____
Date of Birth_____ Age____ Sex M/F ___ **Social Security #**_____
Driver License_____ Expire Date _____ Married ○ Single ○ Widowed ○ Divorced ○
How did you hear about us? ☐ Walk-in ☐ Newspaper/Magazine ☐ Insurance Referral
☐ Internet _____ ☐ Yellow Pages ☐ Local Directory ☐ Referred by (person's name) _____
Vision Insurance: ☐ VSP (Vision Service Plan) ☐ OptumHealth ☐ Medi-Cal
☐ Medicare ☐ EyeMed ☐ Other_____
Employer Name_____ Occupation_____
Subscriber's Social Security No. _____-_____-_____ Group/Policy No._____

PATIENT HISTORY

Reason for seeking eye care today: ☐ Glasses ☐ Contact Lens ☐ Other_____

PATIENT HEALTH HISTORY			FAMILY HEALTH HISTORY	
Yes	No		Yes	No
○	○	Diabetes	○	○
○	○	Macular Degeneration	○	○
○	○	High Blood Pressure	○	○
○	○	High Cholesterol	○	○
○	○	Glaucoma	○	○
○	○	Cataract	○	○
○	○	Retinal Detachment	○	○
○	○	Diabetic Retinopathy	○	○
○	○	Other_____	○	○

Do you have trouble with your vision? ○ No, ○ Yes, If yes, explain_____
Are you taking any medication? ○ No, ○ Yes, If yes, what are you taking?__ _____
Are you allergic to any medication? ○ No, ○ Yes, If yes, which?
Have your eyes ever been dilated? * ○ No, ○ Yes, If yes, when_____

*** Digital Retinal Evaluation** is recommended for proper eye health evaluation. There is an additional fee of $39 for this service. Declining this service may allow a condition to go undetected that could possibly lead to loss of vision or undetected physical health problems. I understand the above notice. INITIAL (_____)
I ○ accept or ○ decline **having the internal part of my eyes photographed with Retinal Digital Camera**

CONSENT TO PROFESSIONAL SERVICES

I hereby authorize **PACIFIC OPTOMETRY** to render optometry services and eye care to me, and I accept the responsibility for payment of services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. All frame and lens purchases are subject to No exchange, No refund. All orders require a 50% deposit and the balance to be paid in full upon pick-up of merchandise within 30 days. I authorize the release of any medical information acquired in the course of my examination or treatment to process insurance claims or further treatment to a referred doctor. I authorize the use of this signature while under the care of Pacific Optometry on all of my insurance submission from Pacific Optometry.

_____ _____ _____
Signature Print name Date