Welcome to the Anaheim Hills Optometric Center Thank You for Selecting Our Office

Section I: **Patient Information** **Date**____________________

Mr./Mrs./Ms/Dr. (please circle) Name:____
Address:____City:______________State:__________Zip__________
Phone (_____)_______________ Work Phone (_____)_______________ Cell Phone (_____)_______________
Date of Birth:_________________________ Social Security Number:_________________________
If Student, Name of School_________________________City/State_________________________ ☐ FT ☐ PT
Spouse or Parent's Name:_________________________Employer_______________ Work Phone__________
Whom may we thank for referring you? ____
Email Address____
Would you like to receive our e-newsletter? ☐ Yes ☐ No Our office will use your email for patient recalls, patient education, new technologies and special offers from our office regarding contact lenses, glasses and Lasik.

Section II **Responsible Party**

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:____Relationship to Patient: _______________
Address:____
City:_________________________State:__________Zip:__________ Phone: (____)_______________
Employer_______________________ Work Phone (____)_______________ SSN#_______________

Section III **Insurance and Payment Information**

Name of Vision Insurance_________________________ Relationship to Subscriber _______________
Name of Medical Insurance_________________________
Method of Payment:(Please circle) Cash Check Credit Card
Please provide your insurance card for office billing. Thank you.

Section IV **Medical and Eye History**

Please circle any that apply to you or are a part of your family history. Please list details on the line following.

Please list medical conditions for which you are being treated. (Circle those that apply) Diabetes Hypertension Thyroid
Cholesterol Heart____
Glaucoma Cataract Eye Injury Lazy Eye Eye Surgery Eye Diseases____________________
Current Medications:____
Medication Allergies:____
Primary Care Physician:_________________________ Phone Number:_______________

Section V **Current Eye Complaints**

Circle all that apply and provide details on the line following. Distance Blur Reading Blur Double Vision Flashing Lights
Floaters Itchy Eyes Watery Eyes Dry/Burning Eyes Headaches____________________
Date of your last eye examination_______________ Do you currently wear contact lenses? Yes No
Brand of Contact Lenses _______________ Are you interested in contact lenses today? Yes No Sunglasses? Yes No
Are you interested in Laser Eye Surgery to reduce your need for glasses of contact lenses? Yes No
Are you interested in products or services that may help you or family members improve sports performance? Yes No
Any hobbies or interests ____

I hereby authorize any necessary medical treatments by the doctors of the Anaheim Hills Optometric Center and agree to be responsible for my bill and any collection fees made necessary to collect payment of services rendered.

Signature____ Date____________________