

# PATIENT INFORMATION

DATE: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Patient ID # (Office Use): \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

EMAIL: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

*\*Used for communication purposes only. For minor patients, please provide the Parent/Guardian information.*

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

ARE YOU A NEW PATIENT? **Y N** LAST EYE EXAM (MONTH/YEAR)? \_\_\_\_\_ Occupation: \_\_\_\_\_

**HEY NEW PATIENT, HOW DID YOU HEAR ABOUT US?** Friend/Family: \_\_\_\_\_ Social Media (i.e. Yelp, Google): \_\_\_\_\_

Insurance: \_\_\_\_\_ Groupon: \_\_\_\_\_ Walk-In: \_\_\_\_\_ Other: \_\_\_\_\_

**PART 1. HEALTH INSURANCE (Your health insurance may differ from your vision insurance)**

**Do you have? MEDICARE or MEDI-CAL (Circle One or Both, leave blank if neither)**

**Other HEALTH INSURANCE: \_\_\_\_\_ (Please provide Name)**

**PART 2. VISION INSURANCE: Are you using vision insurance? Y N**

PLAN NAME: \_\_\_\_\_ ARE YOU THE PRIMARY? Y N

NAME OF PRIMARY MEMBER: \_\_\_\_\_ YOUR RELATIONSHIP TO THE PRIMARY? \_\_\_\_\_

PRIMARY'S INSURANCE ID OR LAST 4 OF SSN: \_\_\_\_\_ PRIMARY'S DATE OF BIRTH: \_\_\_\_\_

*CIRCLE ANY OF THE FOLLOWING FORMS OF PAYMENT YOU WOULD LIKE TO USE TODAY: FSA / HSA / CARE CREDIT*

**PART 3. PERSONAL/FAMILY HEALTH HISTORY (self and blood relatives):**

	YOU	FAM
Dry Eyes		
Severe Headaches		
Red Eyes		
Cataracts		
Head Injuries		
Currently Pregnant		
Currently Nursing		
Seizures		

	YOU	FAM
<b>Diabetes</b>		
Eye Pain		
Glaucoma		
Hay Fever		
Heart Condition		
Floaters		
Thyroid Disease		
Eye Disease		

	YOU	FAM
Inflammatory Disease		
Light Flashes		
Asthma/Allergies		
Eye Surgeries		
Dizziness		
Blurry Vision Far		
Blurry Vision Near		
<b>High Blood Pressure</b>		

LIST ANY CURRENT MEDICAL TREATMENTS/CONDITIONS? \_\_\_\_\_ LAST PHYSICAL: \_\_\_\_\_

**WHAT BRINGS YOU IN TODAY?**

Exam + Glasses: \_\_\_\_\_ Contact Lens Exam: \_\_\_\_\_ Previous CL Wearer: \_\_\_\_\_ Lasik Referral: \_\_\_\_\_ Sunglasses: \_\_\_\_\_

Computer Glasses: \_\_\_\_\_ Red Eye: \_\_\_\_\_ Dry Eyes: \_\_\_\_\_ Eye Pain: \_\_\_\_\_ DMV Referral: \_\_\_\_\_ Other: \_\_\_\_\_

**DISCLAIMER:**

BY SIGNING BELOW, PATIENT AUTHORIZES RELEASE OF INFORMATION TO THEIR INSURANCE COMPANY. PATIENT ALSO AUTHORIZES DR.NASR'S OFFICE TO ACT AS AN AGENT IN HELPING OBTAIN PAYMENT. **WE WILL REVIEW YOUR COVERAGE BASED UPON THE AUTHORIZATION WE WERE ABLE TO OBTAIN FROM YOUR INSURANCE. IF, HOWEVER INSURANCE DENIES COVERAGE FOR ANY SERVICES OR PRODCUTS, PATIENT IS RESPONSIBLE FOR THEIR OWN BILL.** PATIENT ALSO ACKNOWLEDGES READING AND RECEIVING THE NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE.

**PATIENT SIGNATURE (PARENT IF MINOR):** \_\_\_\_\_

**DATE:** \_\_\_\_\_