Welcome to Larkspur Landing Optometry!

Thank you for choosing our office for your eyecare needs. Please take a few moments to complete both sides of this form so that we may better serve you. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help!

Patient Information

Patient's name: □ *Dr* □ *Mr* □ *Mrs* □ *Ms* □ *Miss* ____________________

Date of birth: ____________ Home telephone #: ____________ Work telephone #: ____________

Home address: ____________________ City: ____________ Zip Code: ____________

Employer: ____________________ School: ____________________

How did you first hear about our office? □ Telephone book directory □ Insurance plan directory □ Newsletter

□ Other: ____________________

Whom may we thank for referring you? □ Friend □ Relative □ Co-worker □ Neighbor □ Physician □ Other

Please name: ____________________

Insurance Information

Insurance Company or Carrier: □ Vision Service Plan (VSP) □ Medicare □ Medi-Cal □ Other ____________

Please provide your social security #: ____________________

If different than above, please provide the primary member's social security #: ____________________

If we are a participating provider for your insurance plan, we will directly bill the appropriate third party where and when indicated. Please note that all co-payments and non-covered portions of your balance are due at the time of service.

Signature: ____________________ Date: ____________

FOR OFFICE USE

Ocular History

What is your reason for today's visit to our office? ______________________________

____

Are you interested in either obtaining new ***contact lenses*** or learning more about ***laser vision correction***? __________

When was your last eye examination? ____________ Who was your last eye doctor? ________________

If you wear EYEGLASSES, when do you wear them?

- □ All the time
- □ Distance tasks only
- □ Reading or near tasks only
- □ Computer work
- □ Work
- □ Safety or hazard protection
- □ Sun protection
- □ Other: ______________________

If you wear CONTACT LENSES, what type do you wear?

- □ Soft
- □ Rigid gas permeable
- □ Hard
- □ Extended wear
- □ Disposable or Planned Replacement
- □ Tinted
- □ Astigmatic
- □ Bifocal
- □ Other: ______________________

Do YOU have a history of the following?

- □ Blindness
- □ Cataracts
- □ Glaucoma
- □ Macular degeneration
- □ Diabetic eye disease
- □ Retinal detachment
- □ Crossed, turned, or lazy eye
- □ Other eye disorders: ______________

Does your immediate FAMILY have a history of the following?

- □ Blindness
- □ Cataracts
- □ Glaucoma
- □ Macular degeneration
- □ Diabetic eye disease
- □ Retinal detachment
- □ Crossed, turned, or lazy eye
- □ Other eye disorders: ______________

Have you ever had any of the following conditions involving your eyes?

- □ Eye surgery
- □ Eye injury
- □ Eye infection
- □ Eye disease
- □ Medical treatment
- □ Poor distance vision
- □ Poor near vision
- □ Double vision
- □ Eye strain or fatigue
- □ Glare or sensitivity to light
- □ Severe pain in or around the eyes
- □ Eyes burn, itch, or water
- □ Eyes gritty, sandy, or dry
- □ Spots, dots, floaters, or flashes of light
- □ Poor side vision
- □ Other eye conditions or problems not already mentioned: ______________________

Medical History

How would you describe your general health? □ Good □ Fair □ Poor

When was you last medical examination? ______________ Who is your physician? ______________

Please list any medications that you are currently taking: ______________________

Please list any medical allergies that you have: ______________________

Please check if you □ smoke, □ use alcohol, or □ have a history of substance abuse. □ *I decline to answer.*

Do you have any of the following medical conditions? □ heart disease □ diabetes □ high blood pressure □ frequent headaches □ other medical conditions: ______________________

Has anyone in your family had any of the following medical conditions? □ diabetes □ high blood pressure

Lifestyle/Visual Demands

What is the average number of hours per day that you use a computer? _____ □ continuous □ intermittent

What is your occupation? ______________________

In which activities, hobbies, or sports do you participate? ______________________