

Glendale Optometric Center & Carl S. Shibata, M.D.

Today's Date _____

Patient's Name

Dr. Mr. Mrs. Ms. Miss _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____
 Email Address _____
 Date of Birth _____ / _____ / _____ Social Security Number _____

Whom may we thank for referring you to our office? _____

Employer (or school) _____ **Occupation (or Grade)** _____

Vision Insurance

Primary _____ Subscriber _____ Member ID# _____
 Secondary _____ Subscriber _____ Member ID# _____

Medical Insurance (Provide Insurance Cards)

Primary _____ Subscriber _____ Member ID# _____
 Secondary _____ Subscriber _____ Member ID# _____

Parent or

Person Responsible for account _____ Phone (_____) _____
 Address _____ City _____ State _____ Zip _____
 Social Security Number _____

In Case of Emergency, Contact:

Name _____
 Address _____ City _____ State _____ Zip _____

Personal/Family Medical History

| | | | | | |
|-------------------------|----|-----|-----------------------|----|-----|
| Allergy to Medications | No | Yes | Bleeding Tendency | No | Yes |
| Blindness | No | Yes | Diabetes or "Suspect" | No | Yes |
| Amblyopia/Strabismus | No | Yes | Ear/Nose/Throat | No | Yes |
| Cataract | No | Yes | Gastrointestinal | No | Yes |
| Corneal Ulcer/Abrasion | No | Yes | Genitourinary | No | Yes |
| Cosmetic Eye Surgery | No | Yes | Tear Disease/Disorder | No | Yes |
| Eye Injury | No | Yes | High Blood Pressure | No | Yes |
| Eye Surgery/Laser | No | Yes | Neuro/Psychological | No | Yes |
| Glaucoma | No | Yes | Skin Disorders | No | Yes |
| Retinal Tear/Detachment | No | Yes | Stroke/Blackout | No | Yes |
| Arthritis | No | Yes | Thyroid | No | Yes |
| Asthma/Emphysema | No | Yes | Tuberculosis | No | Yes |
| Cancer | No | Yes | Headaches | No | Yes |
| Macular Degeneration | No | Yes | Other _____ | | |

Do you Use Cigarettes/Tobacco? _____ Alcohol? _____

Other Substances? _____

Current Medications _____

Name of Family Physician _____

When was your last eye exam? _____

Were you dilated? Yes No

Are you currently taking multivitamins? Yes No

What Kind? _____

Are you interested in learning about a nutritional program for healthier eyes? Yes No

Have you ever worn contact lenses? Yes No

What Kind? _____ Solutions? _____

Are you interested in contact lenses? Yes No

Are you interested in Refractive Surgery? Yes No

Hobbies/Activities? _____

Do you...

...work at a computer for long periods of time? Yes No

...have more than one pair of glasses? Yes No

...want information on thinner, lighter lenses? Yes No

...wear bifocals? Yes No

-If yes, are you bothered by head tilting, restricted areas of vision correction, etc.?

...spend time outdoors? Yes No

-if yes, how much time? _____ hrs/weeks

...have prescription sunglasses? Yes No

...have Ultra Violet protection in your sunglasses? Yes No

I authorize the release of payment for medical benefits directly to **Glendale Optometric Center** and the release of any medical information necessary to process all insurance claims.

I understand that the dilating eye drops used as part of the examination may blur vision for an hour or longer and make it unsafe to drive. I will not attempt to drive until I feel safe to do so.

I acknowledge that I am responsible for payment of all services and materials in the event that my insurance denies any claim.

Patient's/Guardian's Signature: _____ Date: _____