STEVEN D. SMITH, OD; AN OPTOMETRIC CORPORATION

RANCHO SANTA MARGARITA OPTOMETRY
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333 Corporate Drive, Suite 120
Ladera Ranch, CA 92694

DEMOGRAPHIC/CONTACT INFORMATION

PATIENT NAME: _____ TODAY'S DATE: _____

DOB: _____ AGE: _____ SEX: MALE / FEMALE SSN: _____ -_____ - _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

BEST NUMBER TO REACH YOU AT (circle one)? HOME / CELL / WORK TEXTING OK (circle one)? YES / NO

EMAIL: _____ REFERRED BY: _____

OCCUPATION:_____ EMPLOYER: _____

MEDICAL INSURANCE INFORMATION

CIRCLE YOUR TYPE OF MEDICAL INSURANCE: PPO HMO MEDICARE OTHER: _____

SUBSCRIBER'S NAME: _____ DOB: _____

RELATION TO PATIENT: SELF / SPOUSE / PARENT SUBSCRIBER'S SSN: _____- _____- _____

PRIMARY MEDICAL INSURANCE: _____ MEMBER ID: _____

GROUP NUMBER: _____ EFFECTIVE DATE: _____

SECONDARY MEDICAL INSURANCE: _____ MEMBER ID: _____

GROUP NUMBER: _____ EFFECTIVE DATE: _____

PAYMENT INFORMATION: Payment for professional services is due at the time of service. All orders for materials require a minimum 50% deposit with any balance due upon delivery. Our office gladly accepts cash, credit cards and debit cards.

INSURANCE INFORMATION: We accept several VISION plans and MEDICAL plans; however we cannot accept assignment for all plans or be responsible for knowing about all types of benefits. Therefore, if you have a plan that we do not accept, you will be asked to pay the office directly and we will provide you with an itemized receipt that you may submit to your insurance for out-of-network benefits. Please understand that vision insurance (ie: VSP, MES, EyeMed, etc.) covers only routine eye examinations for purposes of vision correction and/or eye health screening. All other non-routine visits for complaints regarding red eyes, dry eyes, floaters, glaucoma, eye-related issues due to diabetes or hypertension, cataracts, etc., will be billed through your medical insurance. Please remember that regardless of insurance coverage or insurance company decisions, each patient is ultimately responsible for all charges incurred. Thank you for understanding!

PERSONAL HEALTH INFORMATION: I have read and understand my privacy rights with regards to my personal health information.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

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CONFIDENTIAL HEALTH HISTORY INTAKE FORM

Reason for today's visit: _____

Date of Last Eye Exam: _____ Do you currently wear: [ ] Glasses [ ] Contact Lenses (Soft or Hard/RGP Lenses?)

Please circle any of the following MEDICAL CONDITIONS you have been diagnosed with:

- ADD / ADHD
- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- Benign Prostatic Hyperplasia (BPH)
- Cancer If YES, Type: _____ In Remission: Y / N
- COPD
- Coronary Artery Disease/Heart Disease
- Depression
- Diabetes
  - Type 1/2? _____
  - Last A1C? _____
- GERD
- Hearing Loss
- Hepatitis
- High Blood Pressure
- HIV/AIDS
- High Cholesterol
- Hypothyroidism
- Migraines/Headaches
- Seizures
- Stroke
- Other: _____

Please circle any of the following OCULAR CONDITIONS you have been diagnosed with:

- Blepharitis
- Conjunctivitis
- Cataract
- Diabetic Retinopathy
- Dry Eye Syndrome
- Glaucoma / Glaucoma Suspect
- Keratoconus / Corneal Dystrophy
- Macular Degeneration
- Narrow Angles
- Ocular Hypertension
- Ophthalmic Migraine
- Pseudoexfoliation Syndrome
- Retinal Dystrophy
- Retinal Tear/Detachment
- Strabismus/Lazy Eye
- Other: _____

Please circle if you have had an of the following OCULAR SURGERIES (please list dates/surgeon and which eye [R, L or BOTH] if possible):

- Blepharoplasty
- Cataract Surgery
- Corneal Transplant
- Eye Muscle / Strabismus Surgery
- Intravitreal Injections
- LASIK
- Laser Peripheral Iridotomy (LPI)
- Punctal Plugs
- PRK
- RK
- Retinal Laser
- Yag Casulotomy
- Other: _____

Please list any MEDICATIONS you are currently taking, including eye drops:

_____

_____

Please list any known ALLERGIES:

_____

_____

How many hours per day (on average) do you spend on a computer/digital devices? _____

Do you currently smoke cigarettes/tobacco? YES / FORMER SMOKER / NEVER SMOKER If YES, how many per day? _____

FEMALE PATIENTS: Are you currently pregnant or planning a pregnancy? YES / NO Are you currently nursing? YES / NO

Please circle if you have a FAMILY HISTORY of any of the following conditions:

- Diabetes
- High Blood Pressure
- Stroke
- Heart Disease
- Cancer Type: _____
- Cataracts
- Glaucoma
- Keratoconus
- Macular Degeneration
- Retinal Detachment
- Strabismus/Lazy Eye
- Thyroid Abnormalities
- Other: _____

Preferred Pharmacy and Phone Number: _____

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____