Welcome to Our Office

Please fill out this form legibly and completely. Thank You!

Full Name ____

Name You go by (if different) _____________________________

Home Address ____

City _____________________ State _________ Zip ___________

Home Phone (_______)____________________________________

Work Phone (_______)____________________________________

Cell Phone (_______)_____________________________________

Email Address ____

I give La Mesa Vision Care my permission to use my email address for eye care updates. Yes No

Today's Date ____

Approximate date of last eye exam________________________

Date of Birth _____________________ Sex: M F

Social Security Number ___________________________________

Employer (or School) ___________________________________

Occupation (or Grade) ___________________________________

Emergency Contact Name _________________________________

Emergency Contact Phone _________________________________

Referred By:____ Family_____ Friend_____ Co-worker_____ Radio_____

Doctor Referral______ Eye Care Plan Directory______ Phone Book______ Other (please list)___________________________

Name of Family Members at Home	Relationship	Age	Current Patient of Ours
			Y N
			Y N
			Y N
			Y N

Are you a member of an eye care plan? Y N (if yes, circle your plan below and sign to authorize benefits)

Do you have a Secondary Insurance Carrier? Y N If yes, who is the carrier? _________________________

Vision Service Plan (VSP) Medical Eye Services (MES) Superior Vision Safeguard Medicare Other ______

I authorize the payment of any eye care benefits indicated above to my Doctor of Optometry. I understand that I may have co-payments and overages (costs not paid for by my eye care plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: ____ Date ____________

Medical Insurance ____

Do you participate in a flexible spending account? Y N

How will you settle your account today?

☐ Check ☐ Cash ☐ Credit Card

Personal Medical History					
High Blood Pressure	Y	N	Asthma	Y	N
Heart Disease	Y	N	Eye Disease	Y	N
Diabetes	Y	N	Eye Surgery	Y	N
Cancer	Y	N	Eye Injury	Y	N
Arthritis	Y	N			

Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)

Are you allergic to any Medications? Y N (If yes, please list)

Family Medical History					
High Blood Pressure	Y	N	Glaucoma	Y	N
Diabetes	Y	N	Macular Degeneration	Y	N
Heart Disease	Y	N	Cataracts	Y	N
Cancer	Y	N	Blindness or other Visual Disability	Y	N
Other (please list below)	Y	N			

Other comments on personal or family medical history:

I acknowledge that I have received a copy of La Mesa Vision Care's Notice of Privacy Practices, available from our office receptionist. You can also view it on our website, www.lamesavisioncare.com

Patient Name ____ Today's Date ____________

Signature of patient (or parent/guardian for minors)__________________________ Relationship ____________

EYEWEAR FOR YOUR LIFESTYLE

Life style dispensing has been created to help us design eyewear for all of your activities and visual needs. We are delighted to provide further information on any other visual interest you have.

If you would like information on the following, please check:

___ Contact Lenses
___ Occupational Lenses / Frames
___ Care for the Partially Sighted
___ Dry Eye Treatment
___ Glaucoma
___ Vision and Computers
___ Retinal or Macular Disease
___ Cataract Care
___ Vision and Reading Problems
___ Refractive Surgery
___ Lenses / Frame Advances
___ Sport Lenses / Frames
___ Sports Vision Therapy
___ Vision Therapy
___ Infant Vision Care
___ Eye Exams for 2-Year Olds
___ Private Eyewear Showing in Office or Home
___ Exclusive Eyewear Line
___ Other ________________________________

Do you work on a computer?	___ Yes	___ No
Are you sensitive to sunlight?	___ Yes	___ No
Does driving at night bother you?	___ Yes	___ No
Is preventive eye care important to you?	___ Yes	___ No
Have you ever / always worn a tinted lens?	___ Yes	___ No

What did you like **most** about your last pair of glasses?____

What did you like **least** about your last pair of glasses?____

Please check off any special requirements you may have or any activities in which you engage:

Occupational

___ Protective Industrial
___ Double Segment (high and low)
___ Computer terminal
___ Very Wide Bifocal Segment
___ Special Absorption
(such as X-rays, UV, lasers)
___ Special Frames
___ Tints
___ Outdoor Work
___ Indoor Lighting
___ Other

Hobbies

___ Home Workshop
___ Gardening / Yard Work
___ Stamp / Coin Collecting
___ Needlework, Knitting, etc.
___ Bridge or Other Card Playing
___ Drawing or Painting
___ Computer, Computer Games
___ Photography
___ Other

Eyewear Needs

___ Business
___ Evening / Dressy
___ Sporty
___ Driving
___ Sunglasses
___ Sunglasses that change
___ Daily Wear
___ Reading Only
___ Other

Sports In Which You Participate

___ Racquetball, Tennis, etc.
___ Scuba, Swimming, etc.
___ Contact Sports – Basketball, Football, etc.
___ Bicycling / Running or Jogging
___ Skiing / Snowboarding
___ Golf
___ Boating, Fishing
___ Shooting, Hunting, etc.
___ Other