# Eastside Vision Center

## PATIENT INFORMATION FORM

**Last Name** _____ **First Name** _____

**Address** _____ **City** _____ **State** ____ **Zip** _____

**Communication Preference: Circle one - Home / Cell / Text / Email**

**Home Phone** _____ **Cell Phone** _____ **E-mail** _____

**Sex** (circle) **Male Female** **Date of Birth** _____ **Age** _____

**Soc. Sec. #** _____ **Marital Status** (circle) **Married Single Divorced Widowed**

**Employer** _____ **Employment Status** (circle) **Part Time Full Time**

**How did you hear about us?** _____ **Who is your PCP?** _____

**In an emergency, notify** _____ **Relationship** _____ **Phone** _____

**Bill my insurance for the exam Y / N** _____
(initial)

**I received/read the Privacy Practice Notice** _____
(initial)

**I received/read the Office Policy Form** _____
(initial)

## INSURANCE INFORMATION
(Sponsor's or Self Insurance Information)

**Primary Insurance** _____ **Policy Holder** _____ **ID #** _____

**Relationship to Patient** _____ **Policy Holder's DOB** _____ **Policy Holder's SS#** _____

**Secondary Insurance** _____ **Policy Holder** _____ **ID #** _____

**Relationship to Patient** _____ **Policy Holder's DOB** _____ **Policy Holder's SS#** _____

**Address** _____ **City** _____ **State** ____ **Zip Code** _____
(If different from above)

**Home Phone** _____ **Cell Phone** _____

**Employed by** _____ **Occupation** _____ **Phone** _____

**I certify that I (or my dependent) have insurance coverage with _____. I assign Mario A. Caballero, OD, P.C. all insurance benefits for services rendered. I understand that I am financially responsible for all charges and balances left by my insurance. If my insurance does not compensate Mario Caballero OD, P.C. for his services within 90 days, all balances will become my responsibility to pay.**

_____ _____ _____

**Signature of Patient or Guardian** **Print Name** **Date**

**Revised 3/19/2020**

**HEALTH HISTORY / REVIEW OF SYSTEMS**

**Please help us by telling us if you currently have any of problems in the following areas listed below?**
**(if so, explain the condition in the area provided. If none, leave blank. List medications and allergies below.)**

**EYES: Tell us about your eyes. What is your reason for this visit? Ex., glasses/contacts, loss of vision**

**INTEGUMENTARY: Do you have any conditions of the skin? If so, tell us what they are.**

**NEUROLOGICAL: Ex., headaches, migraines...**

**EARS, NOSE, MOUTH, THROAT: Ex., allergies, hay fever, sinus...**

**RESPIRATORY: Ex., asthma, emphysema, chronic bronchitis...**

**VASCULAR: Ex., diabetes, high blood pressure, cholesterol...**

**GASTROINTESTESTINAL: Ex., GERD, ulcers...**

**BONES/JOINTS/MUSCLES: Ex., Rheumatoid Arthritis/Lupus, muscle/joint pain, gout...**

**LYMPHATIC/HEMATOLOGICAL: Ex., anemia, bleeding disorder...**

**ENDOCRINE: Ex., thyroid/other glands...**

**PSYCHIATRIC: Ex., Insomnia...**

**GENITOURINARY: Ex., genitals, kidneys...**

| LIST OTHER HEALTH ISSUES BELOW: | RECENT | | DO YOU USE: | | PROVIDE US WITH: |
|---|---|---|---|---|---|
| | TRAUMA | SURGERY | TOBACCO | ALCOHOL | Height _____ (inches) |
| | ☐ Eyes | ☐ Eyes | ☐ Yes | ☐ Yes | Weight _____ (pounds) |
| | ☐ Head | ☐ Body | ☐ No | ☐ No | |

| MEDICATIONS | | ALLERGIES | |
|---|---|---|---|
| List any medications you are currently taking | | List all medications that you are allergic to | List all other allergens (environmental) |
| NONE | | NKDA | NKA |
| | | | |
| | | | |
| | | | |
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