

# WELCOME

## MENIFEE VALLEY OPTOMETRY

### Patient Information

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help

(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_ SS/HIC/Patient ID# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Do you prefer to receive calls at  Home  Work  Cell  No Preference  
 Married  Widowed  Single  Minor  Separated  Divorced  Partnered for \_\_\_\_\_ years  
Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Whom may we thank for referring you to us? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### Responsible Party

Name of person responsible for this account \_\_\_\_\_  
Relationship to patient \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer# \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE  No  Yes IF YES, PLEASE COMPLETE THE FOLLOWING

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
Name of Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer# \_\_\_\_\_  
Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

(CONFIDENTIAL)



# PATIENT HISTORY QUESTIONNAIRE

**IMPORTANT:** This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Date of Last Eye Exam \_\_\_\_\_ Dilated? Yes / No Referred By: \_\_\_\_\_  
 Primary Vision Coverage \_\_\_\_\_ Secondary Coverage \_\_\_\_\_

## Medical Information

What is your general health? \_\_\_\_\_

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain \_\_\_\_\_

Diabetes Yes/No Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_  
 Allergies to Medication Yes/No Which? \_\_\_\_\_ Reactions? \_\_\_\_\_  
 Other health problems \_\_\_\_\_  
 Current medication(s) \_\_\_\_\_  
 Have you had any operations? Yes/No Kind? \_\_\_\_\_ When? \_\_\_\_\_  
 Name of family doctor \_\_\_\_\_  
 Date of last visit \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

## Family History

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

## Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? \_\_\_\_\_

Have you had any eye operations? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_

Have you had an eye injury? Yes/No Kind \_\_\_\_\_ Date \_\_\_\_\_

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type \_\_\_\_\_

Additional information \_\_\_\_\_

## Doctor Use Only

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

Reviewed by \_\_\_\_\_  No changes Date \_\_\_\_\_

# Acknowledgement of Receipt of Notice of Privacy Practices

Menifee Valley Optometry  
29950 Haun Road Suite 206  
Menifee, CA 92586

(951) 679-0545

Fax (951) 679-6154

Email: [optomenifee@verizon.net](mailto:optomenifee@verizon.net)

Patient Name: \_\_\_\_\_

**Signing this document signifies that you have received a copy of our  
Notice of Privacy Practices**

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operation involving our office. The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Print Name*

Source of Authority: \_\_\_\_\_

Who may we release information to? (Include all family members who may call to inquire about your care)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_