LVCO
LA VISION CARE OPTOMETRY

PATIENT INFORMATION

☐ New Patient ☐ Previous Patient Today's Date

Last Name _____ First Name _____ ☐Male ☐ Female
Address _____ City _____ State _____ Zip _____
Birth date _____ Home Phone (___)_____ Cell/Work # (___)_____
Email _____ Do you have a Flexible Spending Account ☐ No ☐ Yes
Occupation _____ Employer _____

REASON FOR TODAY'S VISIT

☐ Glasses Exam ☐ Refractive Surgery Evaluation
☐ Contact Lens Exam & Lenses ☐ Other _____
Whom may we thank for referring you? (Friend, Website, Ins. Yelp, etc.) _____

MEDICAL AND EYE HISTORY

Do you have:		Does anyone in your family have:
High Blood Pressure	☐ No ☐ Yes	☐ Yes, who_____
Diabetes	☐ No ☐ Yes	☐ Yes, who_____
Heart Disease	☐ No ☐ Yes	☐ Yes, who_____
Cancer	☐ No ☐ Yes	☐ Yes, who_____
Glaucoma	☐ No ☐ Yes	☐ Yes, who_____
Cataracts	☐ No ☐ Yes	☐ Yes, who_____
Allergies	☐ No ☐ Yes	☐ Yes, who_____
Any Other Health Problems	☐ Self	☐ Family Member_____
Any Eye Problems/Surgeries	☐ Self	☐ Family Member_____

List medications _____
Allergies to medications (allergic reactions) _____
Does your occupation or your hobbies require an impact-resistant lens? Please specify _____

CONTACT LENS INFORMATION

Contact lens wearers require additional testing; consequently a contact lens evaluation fee will be applied.

Do you wear contact lenses? ☐ No ☐ Yes

If yes: ☐ Daily disposable ☐ Weekly/Monthly disposable ☐ RGP (Rigid Gas Permeable)

☐ I remove them before sleeping ☐ I sleep in my contacts ☐ How many days, maximum _____

VISION INSURANCE INFORMATION – IF APPLICABLE

Name of Vision Insurance _____ Your Social Security # _____
Primary Member's Name _____ Primary Member's Birth date _____
Primary Member's SSN # _____ Relation to Member ☐Self ☐Spouse ☐Dependent
Medical Insurance ☐ HMO ☐ Kaiser ☐ PPO ☐ Other _____

I hereby authorize payment of my benefits to LVC Optometry. I understand I am financially responsible for any charges, whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to LVC Optometry. I authorize LVC Opometry to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original. PROFESSIONAL FEES ARE DUE AT TIME SERVICES ARE RENDERED.

Signature _____ Date _____