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Sabre Springs OPTOMETRY

PATIENT INTAKE FORM

Name: Last: _____ First:_____ MI:_____
Date of Birth:_____ Social Security #:_____ Gender: M / F
Home Address:_____ City:_____ State: _____ Zip:_____
Email Address:_____ Phone #:_____ Cell Phone #:_____
Occupation:_____ School Name:_____
Parent/Guardian:_____ Relationship to patient:_____
Emergency Contact Name:_____ Relationship:_____ Phone#:_____
How did you hear about us?_____

Vision Insurance:_____ Member ID#_____ Relation to Primary:_____
Policy Holder: _____ SSN#:_____ Primary's DOB:_____
Medical Insurance:_____ Member ID#_____ Relation to Primary:_____
Policy Holder: _____ SSN#:_____ Primary's DOB:_____

Payment Policy: I agree to assume all financial responsibilities incurred for care. I authorize my insurance carrier(s) to pay directly to Sabre Springs Optometry/Lau and Nguyen, Inc. benefits that are due to me under the terms of my policy. If the above insurance information is not correct, I agree pay in full for all services at the time they were provided. I authorized Sabre Springs Optometry/Lau and Nguyen, Inc. to release information to insurance carriers concerning my illness and treatment. The patient or responsible party will assume all costs incurred in collection of a delinquent account, either by collection of a delinquent account, collection agency, lawyer, or judicial systems.

✗ **Signature**: _____ Date:_____

OCULAR and MEDICAL HISTORY

Date of last eye exam:_____ Primary care doctor:_____
Do you wear glasses or contacts? Y / N_____ Medical Allergy:_____
Do you smoke or drink? How often?_____ Medications you are taking:_____
_____
_____

Check all that applies to you:

___Eye injury
___Eye surgery
___Glaucoma
___Cataract
___Macular degeneration
___Lazy Eye
___Blindness
___Itchy eyes
___Dry eyes
___Watery eyes
___Flashes
___Floaters
___Discharge
Other_____

Check all that applies to your Health:

___Cardiovascular
___High Blood Pressure
___Heart Disease
___Stroke
___Vascular disease
___ Endocrine
___Diabetes type 1 or 2
___Thyroid dysfunction
___Hormonal dysfunction
___Neurological
___Multiple Sclerosis
___ Epilepsy
___Migraine
___Cancer
___Psychiatric
___Depression

___Ears/nose/throat
___Sinusitis
___Dry Mouth
___Hearing Loss
___Allergic/Immunologic
___Rheumatoid Arthritis
___Lupus
___Respiratory Disorder
___Emphysema
___Bronchitis
___Asthma
___COPD
___Gastrointestinal
___Colitis
___Ulcer
___Crohn's

___Genitourinary
___Kidney Disease
___Prostate Disease/cancer
___Hematologic/Lymphatic
___Cholesterol
___Anemia
___Integumentary
___Rosacea
___Psoriasis
___Eczema
___Musculoskeletal
___Osteoarthritis
___Fibromyalgia
___Ankylosing Spondylitis
___Muscular dystrophy
Other_____

Check all that applies to your family members: **Please Specify Relationship**

_____Glaucoma
_____Cataract
_____Macular Degeneration
_____Lazy Eye
_____Retinitis Pigmentosa
_____Blindness
_____Diabetes
_____Heart Disease
_____High Blood Pressure
_____Cancer
_____Thyroid
Other_____