12650 Sabre Springs Pkwy., #203, San Diego, CA 92128
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www.SabreSpringsOptometry.com

PATIENT INTAKE FORM

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

Retinal Photo Consent: As part of your eye exam, the doctors here at Sabre Springs Optometry recommend retinal photography to achieve a more in depth examination of your eyes for diseases and glaucoma. The OptoVue takes digital pictures of the back of the eye to evaluate the optic nerve, blood vessels, and tissues of the back of the eye. In some cases, these images can detect diabetic eye changes, macular degeneration, high blood pressure changes, and glaucoma. It will also serve as a base line for comparison in future years. While taking these images does not replace the need to have your eyes dilated, it is strongly recommended you have images taken. This ensures the doctors are able to get a reasonable view of the eye and your retinal health.

_____ Yes, I want to have the retinal photos today. I understand there will be a $39 co-pay.
_____ No, I do not want retinal photos taken.

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:_____
Initial:_____ **HIPAA RECEIPT:** I acknowledge that I have read Sabre Springs Optometry, Notice of Privacy Practices.

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:

___Diabetes type 1 or 2
___Thyroid dysfunction
___Hormonal dysfunction
___Cardiovascular
___High Blood Pressure
___Heart Disease
___Stroke
___Vascular disease
___Hematologic/Lymphatic
___Cholesterol
___Anemia
___Respiratory Disorder
___Emphysema
___Bronchitis/COPD
___Asthma
___Allergic/Immunologic
___Rheumatoid Arthritis
___Lupus
___Ears/nose/throat
___Sinusitis
___Dry Mouth
___Hearing Loss
___Genitourinary
___Kidney Disease
___Prostate Disease/cancer
___Musculoskeletal
___Osteoarthritis
___Fibromyalgia
___Ankylosing Spondylitis
___Muscular dystrophy
___Gastrointestinal
___Colitis
___Ulcer
___Crohn's
___Rosacea
___Psoriasis
___Eczema
___Neurological
___Multiple Sclerosis
___ Epilepsy
___Psychiatric
___Depression
___Migraine
___Cancer
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_____