Pack & Bianes
VISION CARE
Exceptional, personalized eyecare focused on you
Optometry

□Dr. □ Mr. □ Rev. □ Male
□ Mrs. □ Ms. □Miss □ Female **Date of Birth** _____/_____/_____

Last Name_____ **First Name**_____MI__ __

Address_____ **City**_____ **State**_____ **Zip**_____

Home # (_____)_____ **Mobile #** (_____)_____ **Work #** (_____)_____

SSN _____-_____-_____ Employer_____Occupation_____

Preferred Language: □Eng □Spanish □Other_____ **Race:** □White □African American □Asian □Hispanic □Nat American □Other_____
Ethnic Group: □Non Hispanic □Hispanic **Preferred Communication**: □Phone □Email □Letter □Patient Portal

If you are new to our office, how were your referred?
□ Eye Care Plan Directory □Internet/Website □Sign □Advertisement (which one)_____□ Other_____
□Doctor (Please name) _____ □Patient (Please name) _____
E-MAIL: You will receive appointment reminders, order notifications, yearly recalls, eye care news, and special promotions. You may opt out at any time.

Vision Insurance: □ None □VSP □Tricare □EyeMed □MES □Medi-Cal □Other_____

Member_____ **Relation**_____ **DOB** ____/_____/_____ **ID / SSN** _____

Medical Insurance: □Blue Cross / Shield □Pacificare □Tricare □Cigna □Aetna □Medicare □ Medi-Cal □Other_____

Medical Insurance ID#_____ **Group #**_____ **Provider #**_____

Member_____ **Relation**_____ **DOB** ____/_____/_____ **ID / SSN** _____

Payments and Co-Payments All required payments, co-payments, deductibles, and other out-of-pocket expenses are due in full at the time services are rendered or materials are provided, unless specific financial agreements have been made prior to your scheduled appointment. The office accepts VISA, Master Card, debit cards and personal checks with proper identification. All personal checks returned for any reason are subject to a $25 service charge without exception. In the event of nonpayment, the cost of collection and or court costs and reasonable legal fees is the responsibility of the patient.

Vision Plan and Insurance Benefits It is your responsibility to understand the nature of your vision plan and insurance benefits prior to your scheduled appointment. The employees of PACK & BIANES VISION CARE OPTOMETRY will, to the best of their knowledge and understanding, help answer any questions you may have regarding your vision plan and insurance benefits; however, no guarantee of accuracy regarding eligibility, coverage, or benefit information can be made by anyone other than your vision plan or insurance carrier directly.

Assignment of Benefits I authorize assignment of vision plan and insurance benefits to PACK & BIANES VISION CARE OPTOMETRY for the purpose of determining eligibility, benefits, and collecting for all services rendered and materials provided. In addition, I authorize PACK & BIANES VISION CARE OPTOMETRY and any of its employees to furnish information concerning my present condition to insurance companies and referring doctors as deemed necessary.

Misses, Broken & Cancelled Appointments If a scheduled appointment time is missed, broken, or cancelled for any reason without 24 hours notice, a fee of $35 may be assessed to your account. Please notify the office at least 24 hours in advance if you are unable to keep your appointment.

HIPPA Compliancy I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPPA) for this office. I have read and understood the terms and conditions outlined above, and I hereby certify that all of the information provided is true and accurate to the best of my knowledge and understanding.

Signature:_____ **Date:**_____

Primary Care Physician (or name of Clinic)_____ **Dr.'s Phone #** (____)_____

Please complete the following Medical History for yourself and your family as thoroughly as possible. Many medical conditions may involve the eyes even though it may seem unlikely. Many medications can also have effects on your eyes so please list any and all medications you are currently taking.

Are you pregnant? □No □Yes…If yes, how far along are you?_____ **Are you currently nursing?** □No □Yes

Date of last Physical:_____ **Date of last Eye Exam (here or elsewhere)**_____

HEALTH HISTORY:	Self Y	Self N	Family History *Relationship to you*		Self Y	Self N	Family History *Relationship to you*
Neurological (MS)	□	□	_____	High Blood Pressure	□	□	_____
Headaches	□	□	_____	Heart Disease	□	□	_____
Migraines	□	□	_____	Elevated Cholesterol	□	□	_____
Stroke	□	□	_____	Hepatitis	□	□	_____
Arthritis	□	□	_____	Kidney Disease	□	□	_____
Asthma / Lung Disease	□	□	_____	Lupus	□	□	_____
Cancer	□	□	_____	Thyroid Disorder	□	□	_____
Diabetes	□	□	_____	Anxiety/Depression	□	□	_____
Seizures	□	□	_____	Other	□	□	_____

OCULAR HISTORY:	Self Y	Self N	Family History *Relationship to you*		Self Y	Self N	Family History *Relationship to you*
Glaucoma	□	□	_____	Eye Allergies	□	□	_____
Macular Degeneration	□	□	_____	Blindness	□	□	_____
Cataracts	□	□	_____	Crossed/Lazy Eyes	□	□	_____
Retinal Tear/hole	□	□	_____	Floaters	□	□	_____
Optic Nerve Disease	□	□	_____	Dry Eyes	□	□	_____
Eye Injury	□	□	_____	Other	□	□	_____

Medication Allergies: □None □Penicillin □Sulfa drugs □Other_____

List any Medications you Currently take (including oral contraceptives, OTC medications, aspirin, and home remedies) □None

_____ _____ _____

_____ _____ _____

_____ _____ _____

List all major injuries or surgeries you have had (approx date) *including* EYE injuries / surgery: LASIK/PRK, Cataract etc.

□None _____

SOCIAL HISTORY

Please list hobbies you enjoy?

_____

Do you use tobacco product? □No □Former user □Yes

Do you wear glasses? □No □Yes If yes, how old are your current pairs of glasses? _____

Do you wear contact lenses? □No □Yes Type of lens: □Soft □Toric (for astigmatism) □Gas Permeable (hard) □Multifocal / Monovision

How often do you replace your lenses? □Daily □2 weeks □Monthly □Annual □Other_____

Do you sleep in your lenses? □No □Yes **What is the brand of contact lens worn?**_____

Reason for your visit today? (check all that apply)

□Routine eye health exam □Visual problems at distance □Visual problems at near □Visual problems on computers/tablets

□Eyeglasses □Contact Lenses □Vision Therapy □Laser eye surgery

□Dry eye treatment/management □Eye allergy treatment/management □Eye infection treatment/management

□Other (describe)_____