Ventura Optometric Vision Care
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1280 So. Victoria Suite #100 Ventura, Ca. 93003

WELCOME TO OUR OFFICE

The case history in this form is critical to the evaluation of your vision and health.

Today's Date _____

Title Mr.☐ Mrs.☐ Ms.☐ Miss☐ Master☐ Rev.☐RN☐ Dr.☐ PhD.☐Judge☐

Last Name _____

First Name _____ **Middle Name** _____

Date of Birth _____ **Age** _____ **Gender** ☐M ☐F

Street Address _____

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

Home Phone ( ) _____ **Cell Phone** ( ) _____

Work Phone ( ) _____ **Email** _____

Patient's Soc. Sec.# _____ **Patient's Driver License #** _____

Employer (or School) _____ **Who may we thank for referring you to our office** _____

Occupation (or Grade) _____

Spouse's/Parent's Work# _____

Emergency Contact _____ **Emergency Phone#** ( ) _____

☐spouse ☐family ☐friend

INSURANCE INFORMATION

Vision Insurance _____ **Relationship to Subscriber:** Self☐

Subscriber Name _____ ☐Spouse

Subscriber ID# _____ ☐Child

Subscriber Date of Birth _____ ☐Full Time Student

Subscriber Soc. Sec # _____ ☐Domestic Partner

Primary Medical Insurance _____ **Relationship to Subscriber:** Self☐

☐PPO ☐POS ☐HMO ☐Medicare Part B ☐Spouse

Subscriber Name _____ **Group or Plan #** _____ ☐Child

Subscriber ID# _____ ☐Full Time Student

Subscriber Date of Birth _____ ☐Domestic Partner

Do you have secondary vision insurance? ☐Yes ☐No

Do you have secondary medical insurance? ☐Yes ☐No

Do you participate in a flex spending account? ☐Yes ☐No

How will you settle your account today? Cash☐ Check☐ Credit Card☐

I understand and agree that I am responsible for the full amount of my fee's for any professional services rendered.

It is possible for insurance companies to misquote benefits and coverage for optometric services.

I authorize the realease of any information necessary to process insurance caims. I authorize payment of Optometric and Medical benefits to Dr. Bozek,or Dr. Shiroyama,or Dr. Mitsuuchi for services rendered,and to deposit checks received on this account when made out to either of the Drs' listed above. I certify that this information is true and correct to the best of my knowledge.

Signature _____ **Date** _____

PATIENT HEALTH HISTORY

Patient Name: _____ **DOB**____/____/_____ **Gender:** ☐M ☐F **Race:** ☐ American Indian or Alaska Native/☐ Asian/☐ Black or African American/☐ Hispanic/☐ Native Hawaiian or Other Pacific Islander/☐ White **Preferred Language**: ☐ English ☐ Spanish **Preferred Method of Communication**: ☐ Email ☐ Postal ☐ Telephone **Ethnicity**: ☐ Hispanic or Latino/☐ Native Hawaiian or Other Pacific Islander/☐ Not Hispanic or Latino

Primary Care Physician: _____ Date Last Seen: _____ Occupation: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy):_____

_____

List all major surgeries (Eye Surgery included):_____

_____

List any allergic reactions to **medications or eye drops**: _____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	**Yourself** Yes	No
Cataract	☐	☐
Eye Turn	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐

	Yes	No
Women- Are you pregnant?	☐	☐
Are you breast feeding?	☐	☐

	Family Member Yes	No	**Relationship (Blood Relatives Only)**
Blindness	☐	☐	_____
Eye Turn	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____

Other:_____

Review of Systems Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
☐ None
☐ Lupus (SLE)
☐ Rheumatoid Arthritis
☐ Environmental Allergies
☐ Seasonal Allergies
☐ Other (i.e., Latex)

Ear, Nose and Throat
☐ None
☐ Sinusitis
☐ Upper Respiratory Tract Infection
☐ Other

Gastrointestinal
☐ None
☐ Crohn's Disease
☐ Colitis
☐ Acid Reflux/Ulcer
☐ Other

Skin/Integumentary
☐ None
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Other

Psychiatric
☐ None
☐ Depression
☐ Bi-Polar
☐ Schizophrenia
☐ Other

Cardiovascular
☐ None
☐ High Blood Pressure
☐ Heart Disease
☐ Stroke
☐ Vascular Disease
☐ High Blood Cholesterol

Endocrine/Glands
☐ None
☐ Diabetes
☐ Hormone Dysfunction
☐ Thyroid Dysfunction
☐ Other

Respiratory
☐ None
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Other

Muscle/Skeletal
☐ None
☐ Arthritis
☐ Fibromyalgia
☐ Ankylosing Spondylitis
☐ Other

Genital/Urinary
☐ None
☐ Urinary Tract Infection
☐ HIV Positive
☐ Herpes/Chlamydia
☐ Other

Hematologic/Lymphatic
☐ None
☐ Anemia
☐ Leukemia
☐ Bleeding Disorder
☐ Other

Neurological
☐ None
☐ Multiple Sclerosis
☐ Epilepsy
☐ Tremors
☐ Other

General Health
☐ None
☐ Weight loss/gain
☐ Fever
☐ Fatigue
☐ Trauma

Social
☐ Tobacco Use:
☐ Current Smoker ☐ Former Smoker
☐ Non-Prescription Drugs_____
☐ Alcohol Consumption_____
Weight_____ Height_____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below verifies that I have been offered a copy of Notice of Privacy Practices for Ventura Optometric Vision Care Inc..

Name of Patient (Print)_____ Signature of Patient:_____Date:_____

Signature of Patient Representative (if patient is a minor or an adult unable to sign this form)

Relationship of Patient Representative to Patient _____