

Welcome To Rockridge Optometry

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Thank you for choosing Rockridge Optometry as your vision care provider. We look forward to helping you with all your vision needs. In order to give you the best care possible we ask that you bring the following items with you to your appointment:

- Completed Medical History Form
- Completed Privacy Policy/Consent Form
- Completed Optical Information Sheet
- All Current Eyeglasses and Sunwear
- Current Contact Lens Information (brand, lens name, parameters)
- Vision and Major Medical Insurance Cards

Please be prepared to have your eyes dilated at the time of your examination.

In addition, if you are a contact lens wearer, please WEAR your contacts to your exam. It is best to have them on for at least 3 hours before we see you.

If you have any questions, please do not hesitate to call our office. Should you need to reschedule your appointment please give us 24 hour notice.

We look forward to seeing you on the day of your exam.

Sincerely,

Rockridge Optometry

5321 College Avenue, Oakland, California 94618

Phone: 510.655.3797 ~ Fax: 510.655.3701 ~ www.rockridgeoptometry.com

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: ____/____/____
 Address: _____ Home Phone: _____
 Office Phone: _____
 How did you hear about our office: _____ Birth Date: ____/____/____
 Occupation: _____ Last Eye Exam: ____/____/____
 Do you have vision care insurance? No Yes
 VSP Medicare Medi-Cal Blue Cross MESC Other
 SS # ____/____/____ Insured Members SS# ____/____/____ Insured Members Birth Date ____/____/____

Medical History

Do you have medical insurance? No Yes If yes, who is your carrier? _____
 Name of primary care physician: _____ Last Medical Exam _____
 Are you presently under a physician's care? No Yes If yes, for what conditions? _____

List any medications you take (Including oral contraceptives, aspirin, over the counter medications and home remedies or herbs): _____

Do you have any allergies to medications? No Yes If yes, explain: _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? No Yes
 Do you wear glasses? No Yes
 Do you wear contact lenses? No Yes
 Type of contact lenses: Rigid Soft Extended Wear Other
 Are you interested in Laser Vision Correction? No Yes

Self and Family History

Please note any self and family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE/CONDITIONS	Family	Self	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drooping eyelid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prominent eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Infections or injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Others _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please turn this form over and complete side two

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? No Yes If Yes, do you have visual difficulty when driving? No Yes

If Yes, please describe: _____

Do you use tobacco products? No Yes If Yes, type/amount/how long: _____

Have you ever been exposed to or infected with Gonorrhea Hepatitis HIV Syphilis

Do you engage in any occupational or recreational activities which need special visual requirements (e.g. Computer use, golfing, musical instruments, etc.) _____

Review of Systems

Do you have any problems in the following areas:

System	No	Yes	No	Yes
Constitutional	<input type="checkbox"/>	<input type="checkbox"/>		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>		
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>		
Neurological	<input type="checkbox"/>	<input type="checkbox"/>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
Eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Distorted Visions/Halos	<input type="checkbox"/>	<input type="checkbox"/>		
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Dryness	<input type="checkbox"/>	<input type="checkbox"/>		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>		
Redness	<input type="checkbox"/>	<input type="checkbox"/>		
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>		
Itching	<input type="checkbox"/>	<input type="checkbox"/>		
Burning	<input type="checkbox"/>	<input type="checkbox"/>		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>		
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>		
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>		
Ear, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>		
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>		
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		
Vascular/Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>		
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>		
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>		
Bones/Joints/Muscles	<input type="checkbox"/>	<input type="checkbox"/>		
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>		
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>		
Lymphatic/Hematologic	<input type="checkbox"/>	<input type="checkbox"/>		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>		
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>		
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>		

If you answered Yes to any of the above or have a condition not listed, please explain and list medication: _____

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

ROCKRIDGE OPTOMETRY
5321 College Ave. Oakland, CA 94618

Receipt of Notice of Privacy Policies & Consent Form

Patient Name: _____

Patient ID Number _____ Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Rockridge Optometry.

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient Print Name

Source of Authority: _____