ESCONDIDO EYECARE

613 E Grand Ave, Escondido, CA 92025
(760) 747-7979 escondidoeyedoctor.com

Patient Intake Form

Date: _____ Name: _____ ☐ Male ☐ Female

Birthdate: ____ / ____ / _____ Age: _____ Last Eye Exam: ____ / ____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Alternate Phone: _____

Email: _____ Occupation: _____

Race: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other: _____

Do you plan on buying Glasses today?	☐ Yes	☐ No
Do you plan on buying Blue-Blocker Glasses today?	☐ Yes	☐ No
Do you plan on buying Sunglasses today?	☐ Yes	☐ No
Are you interested in Contact Lenses today?	☐ Yes	☐ No
Are you interested in learning more about Lasik?	☐ Yes	☐ No
Are you happy with your eyelid placement?	☐ Yes	☐ No

Vision Insurance

Primary on the insurance: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent

Date of birth: _____ Social Security Number: _____

Plan name: _____ Group: _____ Member ID: _____

If under 18 years old:

Name of parent/legal guardian: _____

Phone number of parent/legal guardian: _____

Birthday of parent/legal guardian: _____

Insurance Authorization

By agreeing to this section, you are assigning your insurance benefits to **Eric Verret OD Inc.** doing business as **Escondido Eyecare**.

In the event that benefits are not paid or not paid in full by the insurance carrier, the entire or remaining balance is your financial responsibility.

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Main reason for your visit: ☐ None ☐ _____

Other complaints: ☐ None ☐ Distance vision is blurry ☐ Near vision is blurry
☐ Eye strain ☐ Tired eyes ☐ Floaters ☐ Flashes of light ☐ Double vision
☐ Dry eyes ☐ Watery eyes ☐ Red eyes ☐ Eye infection
☐ Itchy eyes / Eye allergies ☐ Eye irritation / foreign body sensation
☐ Pain in or around the eyes ☐ Headaches ☐ Other: _____

Eye Surgeries
☐ None ☐ Lasik ☐ PRK ☐ RK ☐ Cataracts ☐ Glaucoma ☐ Retina
☐ Other: _____

Eye Conditions
☐ None ☐ Cataracts ☐ Glaucoma ☐ Retinopathy ☐ Macular degeneration
☐ Strabismus (crossed eye) ☐ Amblyopia (lazy eye) ☐ Blind
☐ Eye injury / trauma ☐ Other: _____

Eye Drops: ☐ None ☐ _____

Medical Conditions
☐ None ☐ Diabetes ☐ High blood pressure ☐ Cholesterol ☐ Thyroid
☐ Heart disease ☐ Cancer ☐ Asthma ☐ Other: _____

Medications: ☐ None ☐ _____

Medication Allergies: ☐ None ☐ _____

Family Eye Conditions
☐ None ☐ Cataracts ☐ Glaucoma ☐ Retinopathy ☐ Macular degeneration
☐ Strabismus (crossed eye) ☐ Amblyopia (lazy eye) ☐ Blind
☐ Eye injury / trauma ☐ Other: _____

Family Medical Conditions
☐ None ☐ Diabetes ☐ High blood pressure ☐ Cholesterol ☐ Thyroid
☐ Heart disease ☐ Cancer ☐ Asthma ☐ Other: _____

How did you hear about Escondido Eyecare? _____

☐ I acknowledge that a copy of Escondido Eyecare's Notice of Privacy Practices has been made available to me. I am aware that I can refer to it at any time by visiting: https://www.escondidoeyedoctor.com/notice-of-privacy-practices.html

Name: _____ Signature: _____