WELCOME TO GRANADA HILLS OPTOMETRY CENTER

Today's Date: _____ Date of Birth: _____

Name: Mr. Mrs. Ms. Dr. _____
(First) (Last) (MI)

Address:_____
(Number and Street) (City) (Zip code)

Phone #'s: Home (_____) _____ Work: (____) _____X_____ Cell :(____) _____

Driver's License #: _____ (State) _____ Social Security #: _____

E-mail address: _____ Occupation: _____

Whom may we thank for referring you to our office? _____

Method of Payment: Cash _____ Credit Card _____ (Visa/Master Card/American Express/Discover/Care Credit)

INSURANCE INFORMATION (Please present your insurance cards to the receptionist at this time)

Vision Insurance Company: _____ Employer: _____
Insured's Name: _____ Patient's relationship to insured: _____
Insurance Address: _____Insured's DOB:_____
Insured's SS#: _____Insured's ID # (if different that SS#): _____

Medical Insurance Company: _____ Employer: _____
Insured's Name: _____ Patient's relationship to insured: _____
Insurance Address: _____ Insured's DOB: _____
Insured's SS#: _____Insured's ID # (if different that SS#): _____

EMERGENCY / FAMILY INFORMATION

Nearest Relative: _____ Relationship? Spouse/Parent/Child

Address: _____ Phone#: _____

Name of nearest relative not residing with you: _____

Address: _____ Phone#: _____

CONSENT TO TREAT / BILL A MINOR

I hereby give my consent for Granada Hills Optometry Center and its doctors to treat: _____
(Name of minor)

Parent/Guardian Signature: _____ Date: _____

If attending school: _____
(Name of School) (Address)

I authorize Granada Hills Optometry Center, its doctors, and their staff, to correspond with myself and my dependants by phone or by mail, and to release any medical information required by my insurance company. This authorization shall apply to all claims submitted on my behalf or for my dependants. I understand that I am financially responsible to the provider for all charges, including those not covered by my insurance, within 60 days of the date of service.
Verification of insurance benefits is not a guarantee of payment.

Signed:_____ Date:_____

Medical Information

(If you filled out this form last year, please note any changes.)

What is your general health? _____

Do you wear glasses and/or contact lenses? Y/N For what purpose? Distance / Near / Computer / Full-time

If you wear contacts, what type? Daily wear / Extended Wear / Disposable / Colors

Do you have any allergies to medications? Y/N If yes, please list: _____
_____

List any medications, supplements and/or over the counter medications you are taking:
_____
_____

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

Are you pregnant or nursing? _____

Do you or any family member have or have had any of the following conditions (please circle):

EYE/VISION

Crossed eye	Y/N	Self/ Family Member _____ (if family, what is their relationship to you)
Lazy eye	Y/N	Self/ Family Member _____
Drooping eyelid	Y/N	Self/ Family Member _____
Glaucoma	Y/N	Self/ Family Member _____
Cataracts	Y/N	Self/ Family Member _____
Retinal Disease	Y/N	Self/ Family Member _____
Macular Degeneration	Y/N	Self/ Family Member _____
Eye infections	Y/N	Self/ Family Member _____
Blindness	Y/N	Self/ Family Member _____
Chronic Styes	Y/N	Self/ Family Member _____

SYSTEMS

Arthritis	Y/N	Self/ Family Member _____
Blood/Lymph	Y/N	Self/ Family Member _____
Cancer	Y/N	Self/ Family Member _____
Diabetes	Y/N	Self/ Family Member _____
Gastrointestinal	Y/N	Self/ Family Member _____
Heart Disease	Y/N	Self/ Family Member _____
High Blood Pressure	Y/N	Self/ Family Member _____
Kidney Disease	Y/N	Self/ Family Member _____
Lupus	Y/N	Self/ Family Member _____
Muscle/Bones/Joints	Y/N	Self/ Family Member _____
Respiratory / Asthma	Y/N	Self/ Family Member _____
Skin	Y/N	Self/ Family Member _____
Thyroid Disease	Y/N	Self/ Family Member _____
Other _____	Y/N	Self/ Family Member _____

I am interested in _____ Contact Lenses _____ Laser Eye Surgery

If you circled Yes to any of the above, please explain: _____
_____
_____

Doctor's signature: _____ **Date reviewed**: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Granada Hills Optometry Center
18013 Chatsworth St., Granada Hills CA 91344
Phone: (818) 366-2020
Fax: (818) 366-9868
Email: office@ghoc.com

Patient Name: _____ Phone Number: _____

Patient Address: _____

Signing this document signifies that you have received or looked at a copy of our Notice of Privacy Practices

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 healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Granada Hills Optometry Center. An updated copy can be obtained from our website at www.optometrycenter.com.

_____ _____
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:

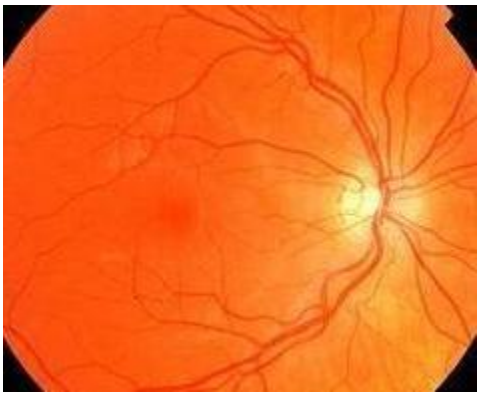
_____ _____
Relationship to Patient Print Name

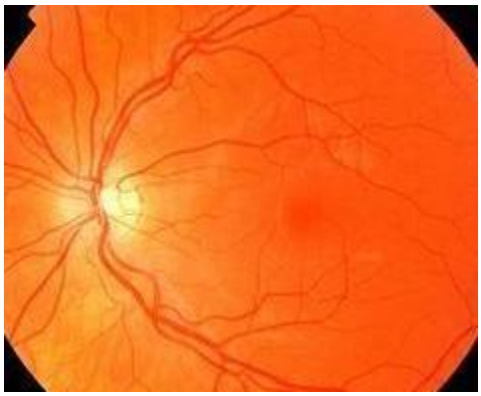
Granada Hills Optometry Center

DIGITAL RETINAL SCREENING CONSENT

All of us at Granada Hills Optometry Center strive to provide the best care for our patients. By using the latest technology in Digital Retinal Photography, we are able to reduce the risk of vision loss and maximize the future health of your eye.

Digital Retinal Photography is a special diagnostic procedure that consists of taking a photograph of the back part (retina) of your eye. This procedure takes only a few minutes and is completely painless. This will serve as an initial point as which to compare as we follow your eye health in subsequent years.





The fee for this additional part of your eye exam is $35. In most cases, this test is **not covered** under your medical or vision insurance. Upon request, this office will advise you of your coverage, and you may be required to submit a receipt for reimbursement from your insurance provider.

_____ **Yes, I want to have retinal photos taken as a part of my eye exam.**

_____ No, I decline the recommendation to have retinal photos taken.