



Welcome to EyeGen Vision Center
16845 Algonquin Street., Huntington Beach, CA 92649

It is our goal to provide you with exceptional service. We appreciate any feedback you can provide us!

Patient Information

Last _____ **First** _____ **Middle Initial** _____ **Title** Dr. Mr. Mrs.
(Circle) Miss. Other _____

Last four of SSN # _____ **Date of Birth** _____ **Gender (Male/Female)** _____

Home Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Number _____ **Cell Number** _____ **Alternate Number** _____

E-Mail (Your E-mail is kept confidential.) _____

How did you hear about EyeGen Vision Center? _____

Emergency Contact Information

Last _____ **First** _____ **Phone Number** _____ **Relationship to Patient** _____

Dilated Eye Exam

Dilation is an important part of a comprehensive eye exam because it enables your eye care professional to view the inside of the eye. Drops placed in each eye widen the pupil, which is the opening in the center of the iris (the colored part of the eye). Dilating the pupil allows more light to enter the eye the same way opening a door allows light into a dark room. Once dilated, each eye is examined using a special magnifying lens that provides a clear view of important tissues at the back of the eye, including the retina, the macula, and the optic nerve. All comprehensive exams include a dilated eye exam at no additional charge. If it is not convenient to have your eyes dilated today, please discuss a follow up appointment with your doctor.

Privacy Rights Acknowledgement

I have read the Privacy Notice and understand my rights contained therein. By way of signature, I acknowledge that EyeGen Vision Center has provided me with a policy regarding the use and disclosure of my protected health care information for the purpose of treatment, payment and health care operations as described in the privacy Notice. A copy shall be as valid as the original.

Signature _____ **Date** _____

Financial Policy Acknowledgement

I understand that I am financially responsible for charges when services are rendered. If my insurance is billed, I am responsible for services, material, or deductibles not covered. I authorize EyeGen Vision Center to release medical information necessary to my insurance company to process claims submitted on my behalf. I understand that if I fail to make payments, my account will be turned over to the collection agency, in which case I will be obligated to pay the costs of collection, court, and legal fees in addition to EyeGen Vision Center. I further understand that any dispute or controversy which may arise between myself and/or my dependent and EyeGen Vision Center or its doctors relating to services provided or activities at 16845 Algonquin St. Huntington Beach, CA 92649, must be submitted to arbitration in lieu of a jury or court trial.

Signature _____ **Date** _____

Office Use Only

How likely are you to recommend us to a friend or co-worker? 1 2 3 4 5 6 7 8 9 10

We use Google Customer Reviews to collect feedback. Can we text you a link to our Google Reviews page? Y / N



EyeGen Vision Center Health Questionnaire

Patient Name: _____ Date of Birth: _____ Date: _____

Primary Care Physician/Location: _____

Date of last physical exam: _____ Height: _____ Weight: _____

Date of last eye exam: _____ Reason for your visit: _____

Occupation/Type of work you do: _____ Employer: _____

Do you have any specific job/school related vision needs we should address?

SPECTACLE/ CONTACT LENSES

Do you presently wear glasses? No Yes: Full-time/Part-Time Distance Only Reading Only Computer Use Only

Do you presently wear contact lenses? Yes No Do you wish to update your contact lens prescription? Yes No

Would you like to see if you are a good candidate for the latest contact lens designs? Yes No

Would you like to discuss laser refractive surgery options today? Yes No

EYE / VISION PROBLEMS (Circle all that apply to this visit)

- | | | |
|---|-------------------------|---------------|
| Blurred vision___with glasses___without glasses | Eye Turn In/Out | Bumps |
| Loss of vision | Loss of Field of Vision | Eye Pain |
| Abrasion | Flashes of Light | Red Eye |
| Eye Allergy/Itchy Eyes | Eye Trauma/Burn | Double Vision |
| Foreign Body Sensation | Floater | |

Any other visual symptoms or eye problems not listed above? _____

COMPUTER USE Do you use a computer? At work _____: Hours/ Day _____ At home _____: Hours/ Day _____

Circle any of the following symptoms that you experience while using the computer:

- | | | |
|----------------|---------------|----------|
| Tired Eyes | Dry Eyes | Headache |
| Blurred Vision | Double Vision | Red Eyes |

Are you interested in designated glasses to make computer work easier? Yes No

EYE HISTORY (Circle all that apply)

- | | | | | | | | | |
|----------------------|----|--------|-----------|----|--------|-----------------------|----|--------|
| Amblyopia (lazy eye) | Me | Family | Blindness | Me | Family | Strabismus (eye turn) | Me | Family |
| Macula degeneration | Me | Family | Cataracts | Me | Family | Color Deficiency | Me | Family |
| Retinal Detachment | Me | Family | Glaucoma | Me | Family | Eye Injury/Trauma | Me | |

Do you have any other eye/vision problems (other than glasses) not listed above? _____

MEDICAL HISTORY (Circle all that apply)

- | | | | | | | | | |
|-----------------------|----|--------|------------------|----|--------|---------------------|----|--------|
| Musculoskeletal | Me | Family | Arthritis | Me | Family | High Blood Pressure | Me | Family |
| Respiratory Disorders | Me | Family | Cancer | Me | Family | High Cholesterol | Me | Family |
| Gastrointestinal | Me | Family | Diabetes | Me | Family | Allergic/Immunology | Me | Family |
| Heart Problems | Me | Family | Blood/Lymph | Me | Family | Head Trauma | Me | |
| Integumentary(Skin) | Me | Family | Neurological | Me | Family | Excessive Headaches | Me | |
| Thyroid Disease | Me | Family | Ears/nose/throat | Me | Family | AIDS/HIV Positive | Me | |

Do you have any other health problems than those circled above? _____

If female, are you currently pregnant or lactating? Yes No

Do you have tuberculosis? Yes No If Yes, treatment for TB? Yes No Date of last tetanus shot _____

Do you have an Advance Directive for health care? _____

SURGICAL HISTORY/ EYE SURGERIES (List any surgeries you have undergone)

EYE MEDICATIONS or EYE DROPS (List - Including over the counter)

SYSTEMIC MEDICATIONS (List all current medications and supplements below)

MEDICATION ALLERGY/ SIDE EFFECTS (List medications and the side effects)

SOCIAL HISTORY Information is strictly confidential. This information can be discussed privately with your doctor if you wish.

- | | | | | |
|-------------|-------------|--------------|-------------------------------|--------------------|
| Tobacco Use | Alcohol Use | Narcotic Use | Sexually Transmitted Diseases | Blood Transfusions |
|-------------|-------------|--------------|-------------------------------|--------------------|

Other: _____

Doctor Initials _____