PATIENT HISTORY FORM

STANDARD OPTOMETRY
標準眼科

4153 El Camino Way Ste A
Palo Alto, CA 94306
tel: (650) 917-1342
email: info@standardopt.com
web: www.standardopt.com

Date: _____Last Name: _____ First Name: _____ MI: _____

Birthday: _____ Age: _____ ☐ Male ☐ Female Preferred Pronoun:_____ Last 4 digits SSN#:_____

Address_____ Address 2 (e.g. Apt #):_____

City_____ State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Employer (or School): _____ Occupation (or Grade): _____

Emergency Contact Name(s): _____ Emergency Contact Phone #: _____

Relation to Emergency Contact: _____

Who may we thank for referring you?_____

If not referred, how did you hear about Standard Optometry?

☐ Saw Building/Signs

☐ Insurance List ☐ Internet: which website?

☐ Advertisement: Newspaper/TV/Radio ☐ Other, please specify：_____

Insurance Information

Vision Insurance Co.：_____ Primary Member's Name：_____

Primary Member's Birthday：_____ Primary Member's Last 4 digits SSN #：_____

Do you have a flex spending account: ☐ Yes ☐ No

Preferred Method of Contact: □ Phone: Home/Work/Cell (please circle option) □ Text/SMS □ Email

Preferred Future Appointment Reminder: □ Postcard/Mailing □ Email reminder □ Text/SMS

Patient Eye History

Date of Last Eye Exam: _____ Date of Last Dilation: _____

Have you had any of these surgeries: Cataract (Date of Surgery:_____) or LASIK (Date of Surgery:_____)

Do you wear glasses? ☐ Yes ☐ No Do you wear prescription sunglasses? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No If No, are you interested in wearing contact lenses? ☐ Yes ☐ No

Have you ever had any eye injury or eye infections? ☐ Yes ☐ No

If yes, please describe：_____

Do you experience any of the following conditions?

☐ Blurry Vision ☐ Itchy Eyes ☐ Watery Eyes ☐ Loss of Vision

☐ Headaches ☐ Red Eyes ☐ Burning Eyes ☐ Flashing Lights

☐ Eye Strain ☐ Sandy/Gritty Eyes ☐ Eye Pain ☐ Floating Spots

☐ Double Vision ☐ Dry Eyes ☐ Fluctuating Vision

Other condition not listed above:_____

Patient Medical History

Physician's Name: _____ City: _____

Date of Last Physical:_____

Pregnant or Nursing? ☐ Yes ☐ No

Any Current Medications? ☐ Yes ☐ No

Please list name(s) and purpose, including over the counter, eye drops, vitamins & birth control pills:

_____
_____
_____

Any Allergies to Medications? ☐ Yes ☐ No

Please list any allergies to medications, food, or the environment:

_____
_____
_____

Have you or any blood relatives had any of the following conditions?

	Yourself	Family
Cataract	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	☐ Yes ☐ No
Lazy Eyes	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No
Eye Blindness	☐ Yes ☐ No	☐ Yes ☐ No
Retinal Detachment	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No

	Yourself	Family
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Lupus	☐ Yes ☐ No	☐ Yes ☐ No

Other condition not listed above：_____

Do you use tobacco? ☐ Yes ☐ No Packs/Day? _____

Do you drink alcohol? ☐ Yes ☐ No Drinks/Day?_____

Financial Policy, Release of Information, & Assignment of Benefits

Standard Optometry extends the courtesy of filing to your insurance company. However, insurance coverage is a contract between you and your insurance company, and you are ultimately responsible for the payment of services rendered.

I agree that all co-payments and /or deductible amounts due will be paid at the time services are rendered, unless payment arrangements have been made. I authorize payment of medical benefits directly to Lisa Lo, O.D. for services rendered and allow the release of any information necessary to obtain payment.

Acknowledgement of Receipt of Privacy Practices & General Consent

I acknowledge that I read and received or was offered a copy of Dr. Lisa C. Lo's Notice of Privacy Practices. I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent / Guardian Date of signature