Pacific Grove Optometric Center
Medical History Form

Name of Patient _____ Date _____

List any **EYE** conditions you have (e.g. cataracts, macular degeneration, glaucoma, retinal problems, etc):

_____

_____

List any **EYE SURGERIES OR INJURIES** you have had and when (e.g. cataract, photorefractive, retina, etc):

_____

_____

List any **MEDICAL** conditions you have (e.g. diabetes, high blood pressure, arthritis, thyroid problems, etc):

_____

_____

List any **MEDICATIONS** you take (If none, list "none"):

_____

_____

List any **MEDICATION ALLERGIES** you have (If none, list "none"):

_____

_____

Do you have **any** of the following problems:

			If yes, explain:
Allergic/Immunological (e.g. environmental allergies, lupus, RA)	N	Y	_____
Musculoskeletal (e.g. fibromyalgia, muscle/joint aches, arthritis)	N	Y	_____
Cardiovascular (e.g. heart disease, chest pain, irregular heartbeat)	N	Y	_____
Gastrointestinal (e.g. heartburn, diarrhea, ulcers, abdominal pain)	N	Y	_____
Neurological (e.g. epilepsy, MS, Alzheimer's, Parkinson's)	N	Y	_____
Constitutional (e.g. fever, unexpected weight loss/gain, fatigue)	N	Y	_____
Genitourinary (e.g. bladder infections, prostate problems, STDs)	N	Y	_____
Psychiatric (e.g. depression, panic disorder, schizophrenia)	N	Y	_____
Ear/Nose/Throat (e.g. sore throat, tinnitus, sinus problems)	N	Y	_____
Hematological/Lymphatic (e.g. anemia, clotting issues, leukemia)	N	Y	_____
Respiratory (e.g. asthma, COPD, emphysema, bronchitis)	N	Y	_____
Endocrine (e.g. thyroid dysfunction, diabetes)	N	Y	_____
Integumentary/Skin (e.g. rashes, rosacea, psoriasis, eczema)	N	Y	_____

(continued on reverse side)

Medical History Form
(continued)

Do you smoke? (Circle one) Never Former Some days Everyday

Do you drink alcohol? (Circle one) Never Rarely Occasionally Frequently

Do you drink caffeine? (Circle one) Never Rarely Occasionally Frequently

For Females Only: Are you pregnant? N Y Are you nursing? N Y

When was your last eye examination? _____ Doctor's Name _____

When was your last physical exam? _____ Doctor's Name _____

Do any of your **direct family members** (father, mother, siblings, children, grandparents) have any of the following conditions (if so, who?):

Glaucoma _____ Macular Degeneration _____ Retinal problems _____

Lazy Eye _____ Cataracts _____ Color Blindness _____

Diabetes _____ High Blood Pressure _____ Thyroid Problems _____

Do you currently wear glasses? N Y If so, what type? _____

Do you currently wear contact lenses? N Y If so, what brand? _____

Other important information (include additional medical/social history, hobbies, special visual needs, etc):

_____

_____

_____

Signature of Patient or Parent/Guardian _____ Date _____

_____ Do Not Write Below This Line _____

☐ Reviewed by Optometrist _____ Date _____

Comments: _____

Pacific Grove Optometric Center
Acknowledgment of Receipt of Notice of Privacy Practices

Pacific Grove Optometric Center
505 Lighthouse Avenue, Suite 101
Pacific Grove, CA 93950
Telephone: (831) 375-5184
Privacy Officer: Michael D. Neunzig, O.D.

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I further acknowledge that a copy of this practice's Notice of Privacy Practices is posted on the wall for review at my convenience, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

Printed name of patient: _____

Signature_____ Date _____

Printed Name _____ Phone: _____

If signing as a personal representative of the patient, please indicate relationship to patient:

- ☐ Parent or legal guardian of minor patient
- ☐ Guardian or conservator of an incompetent person
- ☐ Beneficiary or personal representative of deceased patient

Pacific Grove Optometric Center
Financial Policy

Please be sure to bring your insurance card with you to every visit and let the receptionist know of any changes. Payment in full is due at the time of service, unless we are contracted with your insurance company. If we have a contract with your insurance, it is required that we collect your co-payment upon check-out. If you are unable to pay the required fees at the time of service, our receptionist will gladly reschedule your appointment for a later date.

If we have a contract with your insurance company, we will submit the claim to your insurance. Some services may not be covered by your insurance company. In this case, you would be responsible for the whole charged amount. If, upon submitting a claim to your insurance company you are later deemed to be uncovered for services rendered, you will be responsible for the balance.

Many insurance plans, including Medicare, do not cover routine examinations or refractions (the measurements necessary to determine glasses or contact lens powers). If you have a separate vision plan to cover these services, please let our receptionist know. Otherwise, payment is due at the time of service.

If you plan to use an insurance for which we are not providers or are not on the provider panel, we can provide you with an itemized receipt of services so you can submit it to your insurance company for reimbursement. In this case, full payment is due to us at the time of service and your insurance company will reimburse you (instead of us) directly for any covered amounts.

I have read and understand the Financial Policy.

Signature: _____ Date: _____

Pacific Grove Optometric Center
Patient Registration Form

Date _____

Personal Information:

Patient Name _____ ☐ Single ☐ Married ☐ Widow/Divorced
First Name MI Last Name

Social Security Number _____ M/F _____ DOB _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Family Physician _____ Referred By _____

Emergency Contact _____ Relationship _____ Phone _____

Which primary phone number may we use for correspondence? (Circle **ONE**) Home Cell Work

Insurance Information:

Primary Insurance _____ Insured's SSN/ID# _____

Insured's Name _____ Insured's DOB _____

Insured's Address (if different than above) _____

Insured's Phone (if different than above) _____ Relation to Patient _____

Secondary Insurance _____ Insured's SSN/ID# _____

Insured's Name _____ Insured's DOB _____

Insured's Address (if different than above) _____

Insured's Phone (if different than above) _____ Relation to Patient _____

Financial Assignment and Insurance Authorization:

I authorize payment of insurance benefits to Michael D. Neunzig, O.D./Pacific Grove Optometric Center for professional services rendered. I authorize release of any and all information necessary to process my insurance claim. This assignment will remain in effect until revoked by me in writing.

Signature_____ Date _____
Patient (or Parent/Guardian if patient under 18 years of age)