PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION

Name:________________________________**Date:**____________________________

If child, parent's name(s):____

Date of Birth:_______________ **Social Security Number:**______________________

Phone: Home:_________________________**Work:**___________________________

Cell Phone:____________________**E-mail:**___________________________

Mailing Address:____

____

Social Security Number of the person
who's insurance is being used for this patient:______________________________

Vision Insurance (Primary):____
(Vision Service Plan, Medical Eye Services, Medicare, Mediprime, and
Secure Horizons)

Member Number:_______________________**Insured's Name:**__________________

Vision Insurance (Secondary):____
(For Medicare patients the secondary might be AARP of Blue Cross/Blue
Shield. For a person who has coverage under spouse the secondary ins.
could be Medical Eye Services or Vision Service Plan, etc.)

Member Number:_______________________**Insured's Name:**__________________

Patients' Occupation:___________________**Employer:**________________________

Referred by: ☒Patient:________________________ ☒Phone Book

☒Newspaper ☒Other:______________________________

Policy Note: Payment of services and products is the responsibility of you, the patient (or the parent, if a child is the patient). As a courtesy to the patient, Dr. Ezaki's office will bill your private insurance.
Please note, if insurance does not pay, you are obligated to pay any outstanding balances.
We accept VISA and MASTERCARD.

I have read the above policy on payment and acknowledge my responsibility to pay in full.

Signed:____________________________________**Date:**______________________

PATIENT HISTORY QUESTIONNAIRE

(Completion required be filled out once by patient)

Please answer all questions.

Last name________________________________First name________________________________MI____________
Address____
Telephone (W)____ (H)____
SSN________________-_____________-_____________Date of birth____
Occupation____
Employer____
Emergency contact/Telephone Number____
Date of last eye exam______________________Dilated?___________________Today's date_________________

Medical Information

What is your general health?____

Do you have problems with any of these systems? (please circle all that apply) Eyes Y/N

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/immunologic	Y/N

Please explain____
Diabetes Y/N Type______________________________________Date of diagnosis___________________________
Allergies Y/N Allergic to what?______________________What happens?_________________________________
Medication allergy Y/N What Happens?____ Headaches Y/N
Other health problems____
Current medication(s)____
Have you had any operations? Y/N Kind?__________________________________When?____________________
Do you use cigarettes/tobacco?______________Alcohol?_____________Other substance(s)?________________
Name of family doctor_______________________________________Date of last Visit_____________________
Date of last tetanus shot____

Family History

High Blood Pressure	Y/N	Relation______________	Macular Degeneration	Y/N	Relation_________________
Diabetes	Y/N	Relation______________	Retinal Detachment	Y/N	Relation_________________
Glaucoma	Y/N	Relation______________	Cataracts	Y/N	Relation_________________
Other eye condition(s)	Y/N	What kind?_________________________________			Relation_________________

Personal Eye Information

Have you had any eye operations? Y/N Type__________________________________ Date_________________
Have you had an eye injury? Y/N Kind__________________________________ Date_________________
Do you have Glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred Vision? Y/N
Other eye problems? Y/N What kind?____
Do you wear glasses? Y/N Contact lenses?Y/N Type____
Additional information____
Who may we thank for referring you?____

Doctor's Initials___________________________