

YOUR REASON(S) FOR VISITING OUR OFFICE TODAY: (Please check appropriate items)

- | | | |
|--|---|--|
| <input type="checkbox"/> General annual exam (no specific problem) | <input type="checkbox"/> Blurred distance or near vision | <input type="checkbox"/> Eyes water |
| <input type="checkbox"/> Lost or broken eyeglasses | <input type="checkbox"/> Eyes feel tired | <input type="checkbox"/> Eyes itch |
| <input type="checkbox"/> Want new eyeglasses | <input type="checkbox"/> See "spots" or flashes | <input type="checkbox"/> Eyes feel dry |
| <input type="checkbox"/> Want contact lenses | <input type="checkbox"/> Double vision | <input type="checkbox"/> Pain in eyes |
| _____ Soft _____ Hard (RGP) | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Other (please list) |
| _____ Daily _____ Color | <input type="checkbox"/> Headaches | _____ |
| _____ Bifocal Contact Lenses | <input type="checkbox"/> Problems with present contact lenses | _____ |

LIFESTYLE NEEDS: (Please check appropriate items)

- | | |
|---|---|
| <input type="checkbox"/> I spend a lot of time outdoors | <input type="checkbox"/> I have trouble with close work while: |
| <input type="checkbox"/> I have trouble seeing at night | ___ Reading ___ Hobbies |
| <input type="checkbox"/> I am light sensitive, driving in bright sunlight and glare bothers me | ___ Using My Computer ___ Hours/Day |
| Are you interested in Laser Vision Correction? <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> The Weight/Thickness of my glasses bothers me |
| List any active sports/hobbies: _____ | <input type="checkbox"/> The Bifocal line bothers me, I have to tilt my head to see |

ABOUT YOUR GENERAL HEALTH - PAST OR PRESENT:

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> "Lazy Eyes" | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> List Medications _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Disorders | <input type="checkbox"/> Allergies to Medication? _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eye Injuries | <input type="checkbox"/> Other: _____ |

Has anyone in your family (blood relatives) had any of the above conditions? YES NO

If so, what relative? What condition(s)? Please list here (do not check in list above) _____

OFFICE USE Reviewed By: _____ No Changes Date _____

Welcome to Broadvision Optometry - Dr Mohamadi, O.D.

PATIENT INFORMATION

Name _____ SSN/Patient ID # _____
 Last Name First Name Middle Initial

Address _____ City _____ State _____ Zip Code _____

Home Phone () _____ Cell Phone () _____ E-mail _____

Sex M F Age _____ Birthdate _____ Married Widowed Single Minor

Occupation _____ Separated Divorced Partnered for _____ years

Name of Primary Member _____ Member ID # _____ Birthdate _____

Employer Name _____ Employer Phone () _____

Whom may we thank for referring you? _____

For returning patients only: I certify that my personal information including my address, phone number, health and medical information has not changed since my last eye examination on ___/___/___ (with the exception of: _____) X _____ Date ___/___/___

AUTHORIZATIONS

I certify that I have insurance coverage with _____ and assign directly to _____
 Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization: I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to _____ for any services furnished to me by the provider.
 Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

 Signature of Beneficiary, Guardian or Personal Representative Date

 Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary