Patient Health and History Form

Last Name____ First Name ____

Address____ City_______________________ Zip Code __________________

Hm Phone________________________ Mobile Phone______________________ E-mail __________________________________

Work phone _____________________Employer____________________________________ Occupation ____________________

Address____ City______________________ Zip Code _____________________

Date of Birth_____________________ Past Ocular injuries/surgery ______________________ Spouse _______________________

Physician_________________________ Previous Eye Doctor___________________________ Last Exam ____________________

Do you have: fever, dry cough, shortness of breath, fatigue, loss of taste/smell, chills, sore throat: Yes____ No ____ *Temp*

In the last 2 weeks, have you been in contact with someone who has tested positive to Covid-19: Yes ____ No ____ *Oxygen*

Health issues: Diabetes / HBP / other ____

Medications: ____ List any drug allergies ________________________________

We routinely dilate to check for ocular health. It usually lasts for 3-4 hours. If you prefer not to be dilated, initial here ___________

What is the purpose of your visit today? ____

Would you like any changes made to your glasses or contact lens prescription ____

Are there any eye related issues: ____

This visit is for: General exam _____ Glasses _____ Contact lenses _____ Ocular health issue ________________________

Will you be getting glasses here today ______ Will you need your prescription for glasses/contacts for an outside vendor________

Financially responsible party: Self____ VSP____ MPMG_____ VPA_____ other ____________________________________

This office will try to assist you with your vision insurance and help you to benefit the most from your coverage but you are ultimately responsible for any fees and charges incurred in this office. If your insurance carrier refuses to pay for services or materials, you will be billed for any balance due. You are responsible for all unpaid balances, collection fees, 10% annual interest and all attorney fees if we need to send your account to collections. We will be happy to give you information on your insurance billing but any questions regarding insurance payment should be directed to your insurance carrier.

How did you hear about us: Insurance referral ___ Internet referral ___ Friend/Relative __________________________________

Federal law mandates that we enforce privacy laws to protect your identity. We will only use your health information for the purposes of treatment, payment and health care operations. By my signature, I understand these notices and I consent to allow the office of Leonard Ma, OD to use and disclose my health information for treatment, payment and health care operations.

Signature____ Date ________________________________