PAVELOFF VISION CENTER

PATIENT'S NAME: _____ *BIRTHDATE:* _____/_____/_____

ADDRESS: _____

CITY: _____ *STATE:* _____ *ZIP* _____-_____

PHONE: ( ) _____-_____ *CELL PHONE: ( )_____ - _____* *FAX: ( ) _____-_____*

SSN: _____-_____-_____ *EMPLOYER:* _____

OCCUPATION: _____ *EMAIL:* _____

REFFERED BY: _____ *PRIMARY PHYSICIAN:* _____

How would you like to be reminded of your appointment? *Phone Call____ Text Message_____ Email_____*

PATIENT EMERGENCY INFORMATION

NAME: _____ *RELATIONSHIP:* _____

PHONE NO.( ) _____-_____ *OTHER NO.:( ) _____-_____*

RESPONSIBLE PARTY INFORMATION

If we've made copies of your insurance cards and the insurance is under your name, you do not need to fill out the following information. If the patient named above is not the primary cardholder please fill in the information below. If we do not have copies of your cards we may not be able to bill your insurance.

RESPONSIBLE PARTY / SUBSCRIBER NAME: _____

ADDRESS: _____ *CITY / STATE / ZIP:* _____

SUBSCRIBER'S SSN: _____-_____-_____ *SUBSCRIBER'S D.O.B:* _____/_____/_____

RELATION TO PATIENT: _____ *EMPLOYER:* _____

OCCUPATION: _____ *WORK PHONE: ( ) _____-_____*

ADDRESS: _____ *INSURANCE PHONE #:* _____

PRIMARY INSURANCE: _____ *GROUP NO.:* _____

SECONDARY INSURANCE: _____ *GROUP NO.:* _____

IS THIS VISIT A WORK RELATED INJURY? _____ *CONTACT PERSON / PHONE:* _____

I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSILBE FOR ALL OF THE CHARGES FOR SERVICES RENDERED TO ME OR TO THE PERSON NAMED ABOVE FOR WHICH I AM RESPONSIBLE. I FURTHER UNDERSTAND THAT THE BILLING TO MY INSURANCE COMPANY OR MEDICARE IN NO WAY RELIEVES ME OF MY RESPONSIBILITY FOR PAYMENTS, CO-PAYMENTS, OR PAYMENTS FOR NON-COVERED SERVICES DUE TO THIS OFFICE.

SIGNED: _____ *DATE:* _____/_____/_____

1532 Anacapa Street, Suite 5 • Santa Barbara, CA • 93101 • (805) 682-4459 • Fax (805) 682-5355
www.paveloffvisioncenter.com

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

Date of last eye exam? _____

Do you wear glasses? YES NO Do you wear contact lenses? YES NO

Do you smoke? YES NO FORMER

Please explain the reason for today's visit. Include any symptoms you are currently experiencing:

_____

_____

Please list any medications you take (prescription and over the counter):

_____ _____ _____

_____ _____ _____

Do you have allergies to any medications? : YES NO

If yes, please list: _____

Have you had any eye surgeries?: YES NO

If yes, please list: _____

Have you had any eye injuries?: YES NO

If yes, please list: _____

Have you ever been diagnosed with any diseases of the eye?: YES NO

(i.e. Cataracts, Glaucoma, Macular Degeneration, etc.)

If yes, please list: _____

Please circle any medical conditions you have been treated for or are currently being treated for:

EAR, NOSE, THROAT CARDIOVASCULAR ALLERGIES RESPIRATORY NEUROLOGICAL

SKIN CONDITIONS DIABETES IMMUNOLOGICAL (ARTHRITIS, LUPUS, ETC.) GASTROINTESTINAL

Please circle any FAMILY history of the eye or medical conditions:

BLINDNESS GLAUCOMA MACULAR DEGENERATION CANCER DIABETES

HIGH BLOOD PRESSURE LUPUS ARTHRITIS

Please list any information not included above that you feel may be pertinent to your visit with Dr. Paveloff:

_____

_____