ZIGGY'S Optometry
NEWPORT BEACH

NEW PATIENT INFORMATION – PLEASE PRINT

Last Name	First Name	MI	□ Male □ Female	Age	Date of Birth / /

Home Address	City	State	Zip	How did you hear about us?

Cell Phone ( )	Home Phone ( )	Email

Vision Insurance	Primary Subscriber Name	Subscriber ID or SSN#	Relation to Subscriber

Occupation	Hobbies	By what name do you like to be called?

Reason for today's visit

PERSONAL HEALTH HISTORY

List all medical conditions that you are being treated for:	Medications you take:
List any previous operations:	**Allergies (seasonal and medicational):**

Do you have problems with any of these systems? (*check all that apply*)

Check here ❒ for no health problems.

Eyes		Gastrointestinal		Nervous	
Ears/Nose/Throat		Genitourinary		Endocrine (glands)	
Cardiovascular		Musculoskeletal		Blood/Lymph	
Respiratory		Integumentary (skin)		Allergic/Immunologic	
Autoimmune		Thyroid		Mental	

Please explain: _____

High blood pressure? □ Yes □ No
Diabetes? □ Yes □ No Type _____ Date diagnosed _____
Headaches? □ Yes □ No Frequency _____ Location _____ Onset _____
Are you pregnant? □ Yes □ No

Any other health problems? _____

PERSONAL OCULAR HISTORY

Do you wear glasses?	□ Yes □ No	List any eye injuries:
Do you wear contact lenses?	□ Yes □ No	
Are you interested in contact lenses?	□ Yes □ No	
Are you interested in LASIK?	□ Yes □ No	
List any previously diagnosed eye diseases:		List any previous eye operations (including LASIK):

Do you have problems with any of the following? (*check all that apply*)

Blurred Vision		Dry Eyes		Flashes	
Glare		Itching		Floaters	
Double Vision		Burning			

Other ocular problems: _____

PERSONAL SOCIAL HISTORY

Do you drive?	□ Yes	□ No	♦ Describe any visual difficulty when driving:
Do you use tobacco products?	□ Yes	□ No	♦ If yes, type/amount/how long:
Do you drink alcohol?	□ Yes	□ No	♦ If yes, type/amount/how long:
Do you use recreation drugs?	□ Yes	□ No	♦ If yes, type/amount/how long:

FAMILY HEALTH HISTORY

Do any of your family members have any problems in the following? (*check all that apply*)

Check here ❒ for no family health problems.

□ Arthritis
□ Cancer
□ Diabetes
□ Heart disease
□ Lupus
□ High blood pressure
□ High cholesterol
□ Kidney disease
□ Thyroid disease
□ Other (please specify):
□ Crossed eyes
□ Glaucoma
□ Macular degeneration
□ Retinal disease/detachment

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Privacy Notice

We are required by law to maintain the privacy of and provide individuals this notice of our legal duties and privacy practices with respect to protected health information. This office will only use and disclose necessary personal health information to another party to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam reminders.

By signing below, the patient acknowledges that he/she has been offered a copy of the Notice of Privacy Practices for review and to keep for his/her records.

_____ _____
Patient or legal guardian signature Date

DILATION CONSENT

Please read and check (✓) one of the following statements:

Dilated pupil examination helps the doctors to be able to more thoroughly examine the inside of the eye. It helps to detect hidden disease in the eye which may not cause symptoms but which could cause partial or total visual impairment or be life threatening. Patients with history of diabetes, high blood pressure, high cholesterol, autoimmune disease, cancer, retinal problems, glaucoma, macular degeneration, flashes or floaters, high prescription, or if their vision is not correctable to an acceptable level with no definitive cause are especially encouraged to have an annual dilation. You may experience blurred vision and will be sensitive to light for about 3 hours. Thus, daytime and nighttime driving may be impaired. Dilation may be scheduled for another day if necessary.

❒ **YES**. I want my pupils dilated today and am aware of side-effects of the procedure. I have read and understood the above.

❒ **NO**. I do not want my pupils dilated today. I understand that a condition with the potential for visual loss may exist, and it may go undetected without dilation. I have read and understood the above.

When was the last time you had an eye exam with dilation? _____ ❒ I have never had my eyes dilated.

_____ _____
Patient or legal guardian signature Date

OFFICE USE ONLY

I have reviewed the patient information and ROS thoroughly.

_____ _____
Doctor signature Date