

**Downtown L.A. Vision Center
623 W. 6th St.
Los Angeles, CA 90017**

PATIENT INFORMATION - Please Complete at Each Annual Examination (Please Print)								
<input type="checkbox"/> Mr. <input type="checkbox"/> Master	<input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Ms.	Last Name	First Name	Initial	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Age
Home Address			City	State	Zip	Home Phone	Work Phone	
Employer Name		Employer Address			City	State		
Social Security Number	Your Occupation	Referred By		Signature (If under 18, parent signature required)				
Will you be using any vision benefits or programs? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please fill in the information below.								
Vision Plan Name		Member ID #	Insured's Name		Patient's Relationship to Insured			

Email Address: _____

We will file an insurance claim for any plan under which we are providers. If you have a question about which plans for which we are providers, please ask the receptionist. Payment is expected at time of treatment.

RETURNING PATIENT ONLY

I have reviewed my previous history and acknowledge there is no change	Signature (If under 18 years of age, parent signature required)	Date
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Please indicate any changes below.

PATIENT HISTORY

- Do you have? (please check all that apply)

<input type="checkbox"/> eyestrain	<input type="checkbox"/> pain	<input type="checkbox"/> double vision
<input type="checkbox"/> dry eyes	<input type="checkbox"/> itchy eyes	<input type="checkbox"/> blurred vision with glasses or contacts
<input type="checkbox"/> floaters	<input type="checkbox"/> flashes of light	<input type="checkbox"/> severe or frequent headaches
<input type="checkbox"/> frequent neck and shoulder pain		
 - Name of your primary physician: _____ Date of last physical: _____ HMO Member? No Yes
 - Age of present glasses: _____ Date of last eye exam: _____
 - Have you been examined at Downtown Vision Center before? No Yes When: _____
 - Have your eyes been dilated before? No Yes When: _____
 - Have you had retinal photographs taken before? No Yes When: _____
 - Do you or any blood relatives (grandparents, parents, brothers, sisters, children) have? (please check all that apply)

	Self	Blood Relative		Self	Blood Relative
retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
cataracts	<input type="checkbox"/>	<input type="checkbox"/>	thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	asthma	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	lung disease	<input type="checkbox"/>	<input type="checkbox"/>
high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	<input type="checkbox"/>
 - Are you pregnant? (if applicable) No Yes
 - Are you being treated for any medical condition? No Yes Please List _____
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- Are you taking any medications? No Yes Please List _____
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- Are you allergic to any medication including eye drops? No Yes Please List _____
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- Do you have or have you ever had any eye disease, injury or surgery? No Yes
- If yes please explain: _____