See Breeze Optometry

19746 Beach Blvd.
Huntington Beach, CA 92648
714-964-3811

Patient Medical History Form

Patient Name: _____ M/F (circle one) Today's Date: ___/___/___

Home Address: _____ Cell: _____

City: _____ State: _____ Zip: _____ Home:_____

SSN#: _____ Last Eye Exam: _____ Age: _____ Birth Date: ____/____/___

Occupation: _____ Email: _____

FAMILY PHYSICIAN AND/OR PRIMARY HEALTH CARE PROVIDER

Name of Medical Doctor: _____ Last Medical Exam: _____

Address: _____ Dr.'s Phone: _____

INSURANCE INFORMATION

Insured Name: _____ M/F (circle one) Insured Birth Date: ___/___/___

Insured SSN#: _____

Patient Relationship to Insured (circle one): Self Spouse Child Domestic Partner Student

Vision Insurance Plan: _____ ID #: _____

Medical Insurance Plan: _____ HMO / PPO ID #: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Referred by (Patient Name): _____ ☐ Friend/Relative ☐ Social Media

☐ Medical Insurance ☐ Vision Insurance ☐ Location ☐ Internet

HIPPA STATEMENT

In the course of providing service to you, we create, receive, and share health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. I have reviewed the **Notice of Privacy Practices** and can receive an additional copy for my records at any time.

INSURANCE RESPONSIBILITY STATEMENT

As a courtesy to our patients, we will bill your insurance company on your behalf. Should my insurance company not pay the amount quoted to me for services and/or materials, I am personally responsible for payment. When a medical condition exists such as (but not limited to) cataracts, glaucoma, dry eyes, diabetes, high blood pressure, or any other condition related to the health of the eye, it will be necessary for the doctor to perform a full and comprehensive ocular health exam. This exam may include further testing beyond the scope of a routine eye exam. With a medical diagnosis, your exam and testing will be billed to your medical insurance and you will be responsible for any co-pays, deductibles and/or coinsurance as dictated by your specific plan. I have reviewed the **Insurance Explanations** and can receive an additional copy for my records at any time.

I authorize the release of any medical records for myself or my dependent(s) that may be required in order to process any claims on my behalf, or to confer with other medical doctors, or pharmacists, for continuity of medical care, which may include methods via e-mail, internet, phone, or fax. I authorize payment of medical benefits to Jeffrey S. Dang Inc.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE STATEMENTS.

_____ _____

Signature of Patient or Guardian Date

PRESENT MEDICAL HISTORY
Have you been diagnosed with or have had any of the following? Please check all that apply.

Constitutional
☐ Developmental Disabilities
☐ Cancer

Ear/Nose/Throat (ENT)
☐ Hearing Loss
☐ Sinusitis
☐ Dry Mouth

Neurological
☐ Multiple Sclerosis
☐ Migraine
☐ Autism

Psychiatric
☐ Depression
☐ Attention Deficit

Cardiovascular
☐ Hypertension
☐ Stroke/CVA
☐ Heart Disease

Respiratory
☐ Asthma
☐ Sleep Apnea

Gastrointestinal
☐ Crohn's
☐ Colitis

Genitourinary
☐ Kidney Disease
☐ Pregnant/Nursing

Musculoskeletal
☐ Osteoarthritis
☐ Arthritis
☐ Muscular Dystrophy

Integumentary
☐ Rosacea
☐ Herpes/Cold Sores
☐ Herpes Zoster/Shingles

Endocrine
☐ Diabetes Type 2
☐ Diabetes Type 1
☐ Thyroid Dysfunction

Hematologic/Lymphatic
☐ Anemia
☐ High Cholesterol

☐ **None of the above**
☐ **Other**: _____

CURRENT MEDICATIONS
List any medications you are currently taking: _____
List any drug/environmental allergies: _____

PAST/PRESENT OCULAR HISTORY
Have you been diagnosed with or have had any of the following? Please check all that apply.

☐ Eye Injury
☐ Amblyopia
☐ Dry Eye
☐ Glaucoma
☐ Retinal Degeneration
☐ Retinal Detachment
☐ Cataract
☐ Floaters/Flashes
☐ Keratoconus
☐ Macular Degeneration
☐ Diabetic Retinopathy
☐ Eye Surgery
☐ Eye Strain

☐ **None of the above**
☐ **Other**: _____

SOCIAL HISTORY
Do you Drink? ☐ No ☐ Yes Amount: _____
Do you use Tobacco? ☐ No ☐ Yes Amount: _____
Smoking Status ☐ Never smoker ☐ Former smoker ☐ Current everyday smoker
Hobbies (i.e. sports, reading, etc.): _____

FAMILY HISTORY
Has anyone in your **family** (blood relatives only) been diagnosed with or have had any of the following? Please check all that apply.

☐ **Hypertension**
☐ Father
☐ Mother
☐ Brother
☐ Sister

☐ **Cancer**
☐ Father
☐ Mother
☐ Brother
☐ Sister

☐ **Diabetes**
☐ Father
☐ Mother
☐ Brother
☐ Sister

☐ **Glaucoma**
☐ Father
☐ Mother
☐ Brother
☐ Sister

☐ **Cataract**
☐ Father
☐ Mother
☐ Brother
☐ Sister

☐ **Macular Degeneration**
☐ Father
☐ Mother
☐ Brother
☐ Sister

☐ **None of the above**
☐ **Other**: _____