Welcome To Our Office

Fabrizio Optometry
8135 Painter Ave. Suite 100, Whittier, CA 90602 (562) 945-7300

Patient Name: _____
Last Name *First Name* *Middle Name or Nickname*

Home Address: _____
Number & Street *City* *State & Zip Code*

Phone Numbers: _____
Home *Work* *Cell*

E-mail Address: _____

Sex: Male Female **Date of Birth:** _____
(please circle one)

Social Security Number: _____

Marital Status: Single Married Separated Divorced Widowed
(please circle one)

Employer: _____
Company Name *Occupation*

Drivers License: _____
Number *Expiration Date* *State*

Insurance Company: EyeMed VSP MES Optum Health Medicare Other - _____
(please circle one)

Insurance: _____ Self Spouse Child Other
ID# *Policy Group #* *Relationship to Insured*

Responsible Party: _____
Name of Insured Person *Date of Birth and Social Security Number of Insured Person*

I give permission for the office of Suzanne M. Fabrizio, O.D. to bill my insurance. I assume complete responsibility for all payments of services that are not payable by my insurance, including ineligibility, benefit error, lack of contractual relationship or denial of medical necessity.

Signed: _____
Patient / Parent / Guardian / Conservator *Date*

Privacy Rights Acknowledgement

I have read the Fabrizio Optometry Privacy Notice and understand my rights contained therein. By way of my signature, I acknowledge that Fabrizio Optometry has provided me with a policy regarding the use and disclosure on my protected healthcare information for the purpose of treatment, payment, and healthcare operations as described in the Privacy Notice. A copy shall be as valid as the original.

Signed: _____
Date

Please Continue On Next Page

Patient Name:

Last Name *First Name* *Date of Birth*

Today's Date: **Occupation:**

Chief Complaint:

Referred By:

Name of Family Doctor:

	Disorder	Patient		Family Member		Relationship
Family History	Cataracts	Yes	No	Yes	No	
	Blindness	Yes	No	Yes	No	
	Glaucoma	Yes	No	Yes	No	
	Eye Muscle Disorder	Yes	No	Yes	No	
	Macular Degeneration	Yes	No	Yes	No	
	Cancer	Yes	No	Yes	No	
	Diabetes	Yes	No	Yes	No	
	Heart Disease	Yes	No	Yes	No	
	High Blood Pressure	Yes	No	Yes	No	
	Other	Yes	No	Yes	No	

Systemic History	**Ears, Nose, Throat**	Yes	No	*Sinus Ear Infection Dry Mouth*
	Cardiovascular	Yes	No	*High Blood Pressure Heart Attack Stroke*
	Respiratory	Yes	No	*Asthma Emphysema*
	Gastrointestinal	Yes	No	*Stomach Ulcers Intestinal Disease*
	Kidney, Bladder	Yes	No	
	Muscles, Bones, Joints	Yes	No	*Arthritis*
	Skin	Yes	No	*Acne Skin Cancer*
	Neurological	Yes	No	*Multiple Sclerosis Migraine*
	Psychiatric	Yes	No	*Anxiety Depression Insomnia*
	Endocrine	Yes	No	*Diabetes Hypothyroid*
	Other			
	Have you ever had any eye injuries, or eye surgeries? *Describe:*		Yes	No
	Have you ever had any other surgeries? *Describe:*		Yes	No

Medications

Are you allergic to any medications? Yes No

Describe:

Are you currently taking any medication? Yes No

(please list name, strength, and frequency)

Do you smoke now?	Yes	No	
Have you ever smoked?	Yes	No	*When did you stop smoking?*
Do you drink alcoholic beverages?	Yes	No	*never socially 2-3x a week daily*
Do you exercise?	Yes	No	*never occasionally weekly daily*