Welcome Back!

613 E Grand Ave

Escondido Ca 92025

Thank you for continuing to choose us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to update the following information. If you have any questions, please ask.

First Name:		**Phone#:**	
Last Name:		**Alternate Phone#:**	
Preferred Name:		**Home Address:**	
Email:		**City / ZIP:**	

Primary Insurance		**Secondary Insurance**	
Policy #		**Policy #:**	
Policy Holder Name:		**Policy Holder DOB:**	
Primary Care Physician:		**Policy Holder Last 4 Soc Sec #**	

Do You Smoke?	☐ **Yes** ☐ **No**	**Are You Pregnant or Nursing?**	☐ **Yes** ☐ **No**	**List all medications**	
Do You Drink Alcohol?	☐ **Yes** ☐ **No**	**Any Allergies?**	☐ Yes ☐ No	**List allergies to medications**	

HEALTH HISTORY	SELF	RELATIVE	NONE	REASON FOR YOUR VISIT TODAY	
Diabetes	☐	☐	☐	Blurred Vision	☐
High Blood Pressure	☐	☐	☐	Burning	☐
Thyroid Problems	☐	☐	☐	Dry Eye	☐
Heart Disease	☐	☐	☐	Eye Pain	☐
Asthma	☐	☐	☐	Eye Strain	☐
Cancer	☐	☐	☐	Flashing Lights	☐
Seizures	☐	☐	☐	Floaters	☐
Stroke	☐	☐	☐	Headaches	☐
Glaucoma	☐	☐	☐	Itching	☐
Cataracts	☐	☐	☐	Night Glare	☐
Macular Degenerat.	☐	☐	☐	Sensitive to Light	☐
Retinal Disease	☐	☐	☐	Redness	☐
Eye Surgery	☐	☐	☐	Watering	☐
Eye Injury	☐	☐	☐		
Other:				Other:	

I give my consent to Escondido Eyecare to provide services for me and /or my family. I understand that if today's examination is billed as medical eye care, both my vision and medical insurances may be billed. I understand that I'm responsible for fees not paid by my insurance.