Welcome To Our Office!

Thank you for choosing 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 complete the following information.

Escondido Eye Care

613 E. Grand Ave

Esconddo, CA 92025

First Name:		**Phone#:**	
Last Name:		**Alternative Phone#:**	
Preferred Name:		**Email:**	
Date of Birth:		**Home Address:**	
Gender:	☐ **Male** ☐ **Female**	**City / ZIP:**	
Preferred Language:		**SocSec#**	
Race:		**Ethnicity:**	☐ **Hispanic / Latino** ☐ **Non-Hispanic / Latino**

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

How Did You Hear About Us:	☐ **Phone Book** ☐ **School** ☐ **Insurance** ☐ **Drive By**	**Who may we thank for Referring you?**	
Do You Smoke?	☐ **Yes** ☐ **No**	**Are You Pregnant?**	☐ **Yes** ☐ **No**
Do You Drink Alcohol?	☐ **Yes** ☐ **No**	**Are You Nursing?**	☐ **Yes** ☐ **No**

Please Complete Other SIde

Diabetes	☐	☐	☐	Blurred Vision	☐
High Blood Pressure	☐	☐	☐	Burning	☐
Thyroid Problems	☐	☐	☐	Dry Eye	☐
Heart Disease	☐	☐	☐	Eye Pain	☐
Asthma	☐	☐	☐	Eye Strain	☐
Cancer	☐	☐	☐	Flashing Lights	☐
Stroke	☐	☐	☐	Floaters	☐
Glaucoma	☐	☐	☐	Headaches	☐
Cataracts	☐	☐	☐	Itching	☐
Macular Degeneration	☐	☐	☐	Night Glare	☐
Retinal Disease	☐	☐	☐	Redness	☐
Eye Surgery	☐	☐	☐	Sensitive to Light	☐
Eye Injury	☐	☐	☐	Watering	☐
Other				Other	

Patient's Name: _____

List Any Allergies	_____	_____
	_____	_____
	_____	_____

Medications *(no need to write if list provided)*	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Please Read and Sign:

I authorize Escondido Eyecare to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Escondido Eyecare. Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems). Medical insurance must be used for medical eye care. I understand that if I have both types of insurance plans it may be necessary to bill some services to one plan and some services to the other, using a procedure called coordination of benefits to do this properly and to minimize out-of-pocket expense. I understand that if fees are not paid by my insurance, I am still responsible and will be billed for them. Accounts 90 days old are subject to collections, and there will be a service charge for any bounced checks.

HIPAA Notice of Privacy Policies: **I understand I may obtain a copy of Escondido Eye Care Notice of Privacy Practices upon request.**		**Health related communications and reminders:** **I permit Escondido Eye Care to communicate and remind me about my health related issues and appointments by phone, texting and/or email.**	
Signature:		**Date:**	