HOSPITALITY EYECARE
CENTER *of* OPTOMETRY

ph 909 383 5000
fx 909 383 5010

164 W Hospitality Lane, Suite 7
San Bernardino, CA 92408

www.SeeToLive.com

EYECARE REGISTRATION AND HISTORY

PATIENT INFORMATION

Date ________

Patient ____

Address ____

____

City State Zip

Email ____

Sex: [ ] M [ ] F Age _________ Birthdate __________

Patient SS# ____

Occupation ____

Employer ____

Employer Phone # ________________________________

Employer Address ________________________________

Spouse's Name ____________________________________

Birthdate ______________ SS# ______________________

Occupation ____

Spouse's Employer _________________________________

Whom may we thank for referring you? ______________

____

INSURANCE

Who is responsible for this account? _____________________

Relationship to Patient ________________________________

Insurance Co. ____

Group # ____

Is patient covered by additional Insurance? [ ] Yes [ ] No

Subscriber Name ______________________________________

Birthdate ______________ SS# __________________________

Relationship to Patient ________________________________

Insurance Co. ____

Group # ____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to Hospitality Eyecare Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature ____________________________

Relationship ______________________ Date ______________

PHONE NUMBERS

Home ________________ Work ____________________ Ext. _________ Spouse's Work ______________________

Best time and place to reach you ____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ____ Relationship __________________________________

Home Phone ____ Work Phone ___________________________________

MEDICATIONS

List medications you are currently taking, including eye drops, over the counter medications & herbs:

____

____

____

Pharmacy Name ___________________________________

Phone ____

ALLERGIES

List your allergies to medication or other substances:

____

____

____

____

____

____

HEALTH HISTORY

Physician's Name ____ Date of last visit __________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	[ ] Yes [ ]No	[ ] Yes [ ]No	Hepatitis (Type _____)	[ ] Yes [ ]No	[ ] Yes [ ]No
Arthritis	[ ] Yes [ ]No	[ ] Yes [ ]No	High Blood Pressure	[ ] Yes [ ]No	[ ] Yes [ ]No
Artificial Heart Valve	[ ] Yes [ ]No	[ ] Yes [ ]No	Kidney Disease	[ ] Yes [ ]No	[ ] Yes [ ]No
Artificial Joints	[ ] Yes [ ]No	[ ] Yes [ ]No	Lazy Eye	[ ] Yes [ ]No	[ ] Yes [ ]No
Asthma	[ ] Yes [ ]No	[ ] Yes [ ]No	Lupus	[ ] Yes [ ]No	[ ] Yes [ ]No
Bleeding	[ ] Yes [ ]No	[ ] Yes [ ]No	Migraine Headaches	[ ] Yes [ ]No	[ ] Yes [ ]No
Blindness	[ ] Yes [ ]No	[ ] Yes [ ]No	Pacemaker	[ ] Yes [ ]No	[ ] Yes [ ]No
Cancer	[ ] Yes [ ]No	[ ] Yes [ ]No	Poor Color Vision	[ ] Yes [ ]No	[ ] Yes [ ]No
Cataracts	[ ] Yes [ ]No	[ ] Yes [ ]No	Retinal Disease	[ ] Yes [ ]No	[ ] Yes [ ]No
Chemical Dependency	[ ] Yes [ ]No	[ ] Yes [ ]No	Rheumatic Fever	[ ] Yes [ ]No	[ ] Yes [ ]No
Diabetes	[ ] Yes [ ]No	[ ] Yes [ ]No	Shingles	[ ] Yes [ ]No	[ ] Yes [ ]No
Drug Sensitivity	[ ] Yes [ ]No	[ ] Yes [ ]No	Skin Conditions	[ ] Yes [ ]No	[ ] Yes [ ]No
Emphysema	[ ] Yes [ ]No	[ ] Yes [ ]No	Stroke	[ ] Yes [ ]No	[ ] Yes [ ]No
Epilepsy	[ ] Yes [ ]No	[ ] Yes [ ]No	Thyroid Conditions	[ ] Yes [ ]No	[ ] Yes [ ]No
Eye Surgery	[ ] Yes [ ]No	[ ] Yes [ ]No	Tuberculosis	[ ] Yes [ ]No	[ ] Yes [ ]No
Glaucoma	[ ] Yes [ ]No	[ ] Yes [ ]No	Turned Eye	[ ] Yes [ ]No	[ ] Yes [ ]No
Hay Fever	[ ] Yes [ ]No	[ ] Yes [ ]No	Are you pregnant? ___________	Number of Children __________	
Heart Condition	[ ] Yes [ ]No	[ ] Yes [ ]No	Tobacco use ________________	Alcohol use ________________	

EYE HEALTH HISTORY: experiencing any of the following?

Place a Mark on "Yes" or "No" to indicate if you have had any of the following:

		Bloodshot Eyes	[ ] Yes [ ]No	Floaters or Spots	[ ] Yes [ ]No
		Blurred Vision - Distance	[ ] Yes [ ]No	Glaucoma	[ ] Yes [ ]No
		Blurred Vision - Near	[ ] Yes [ ]No	Headaches	[ ] Yes [ ]No
Do you use a computer		Burning Eyes	[ ] Yes [ ]No	Itching Eyes	[ ] Yes [ ]No
more than 30 minutes a day?	[ ] Yes [ ] No	Cataracts	[ ] Yes [ ]No	Light Sensitivity	[ ] Yes [ ]No
		Poor Color Vision	[ ] Yes [ ]No	Loss of Vision	[ ] Yes [ ]No
Do you wear sunglasses		Crossed Eyes	[ ] Yes [ ]No	Migraine Headaches	[ ] Yes [ ]No
with UV protection?	[ ] Yes [ ] No	Discharge from Eyes	[ ] Yes [ ]No	Poor Night Vision	[ ] Yes [ ]No
		Dizzy Spells	[ ] Yes [ ]No	Red Eyes	[ ] Yes [ ]No
Are you interested in		Double Vision	[ ] Yes [ ]No	Seeing Halos	[ ] Yes [ ]No
Contact Lenses?	[ ] Yes [ ] No	Dry Eyes	[ ] Yes [ ]No	Seeing Flashes	[ ] Yes [ ]No
		Eye infection	[ ] Yes [ ]No	Temporary Loss of Vision	[ ] Yes [ ]No
Are you interested in Lasik?	[ ] Yes [ ] No	Eye injury	[ ] Yes [ ]No	Twitching Eyelid	[ ] Yes [ ]No

Thank you for providing this information. It helps me provide optimal eye health and vision care for you!
Dr. Cynthia Corbett

PATIENT ACKNOWLEDGMENT

Acknowledgment Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of this entity. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We strongly encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our web site at www.SeeToLive.com or contacting our office at:

Hospitality Eyecare Center of Optometry

164 W. Hospitality Lane, Suite 7
San Bernardino, CA 92408
909.383.5000
Info@SeeToLive.com

Signature of patient/legal representative:_______________________________
Date/Time:______________

INABILITY TO OBTAIN PATIENT ACKNOWLEDGMENT

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining acknowledgment , and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Patient incapacitated/ unable to sign

☐ Other (Please specify)

Patent Name:____
Patient social security number_____________________________
Signature of Facility Representative:_______________________________
Date/Time:____________________

HOSPITALITY EYECARE
CENTER of OPTOMETRY
ph 909 383 5000
fx 909 383 5010
164 W Hospitality Lane, Suite 7
San Bernardino, CA 92408
www.SeeToLive.com

DEVELOPMENTAL HISTORY FORM

Child's Name____Birthday______/_____/_____Age_____yr_____mo
Grade__________School's Name and Address____
Teacher's Name____
Mother's Name____________________Occupation___________________________Phone____________________
Father's Name____________________Occupation___________________________Phone____________________
Mailing Address____
Who referred you to Hospitality Eyecare Center?___________________________Number of children in family____

I. Please state any major concerns you have for your child's eyes and vision:

____

____

II. Vision:

	Yes	No	Comments
1. Headaches			
2. Blurred distance vision			
3. Blurred reading vision			
4. Holds books closer than normal			
5. Eyes hurt			
6. Eyes tire			
7. Double vision			
8. Eye turn (crossed or wall-eyed)			
9. Blinks excessively			
10. Covers one eye while doing homework			

III. School:

	Yes	No	Comments
1. Is your child having problems in school?			
2. Does your child like the teacher?			
3. Is the school satisfied with the child's performance?			
4. Are you satisfied with the child's performance?			
5. Do grades really show his/her ability?			
6. Is there trouble completing written assignments?			
7. Does your child lose his/her place while reading?			
8. Does your child misread words that are known?			

Continued

IV. Behaviors: Please rate your child on the following items (place a number in the blank space to the left of the item that best describes his/her school or home behavior).

1 - Always 2 - Frequently 3 - Occasionally 4 - Rarely 5 - Never 6 - Unknown

_____ Hyperactive Easily
_____ Distracted
_____ Short Attention Span
_____ Easily Frustrated
_____ Impulsive
_____ Easily Fatigued
_____ Poor Ability to Organize Work
_____ Indistinct Speech/Awkward/Clumsy
_____ Poor Peer Group Relationships
_____ Behavior Problems
_____ Emotional Problems
_____ Confusion Following a Series of Verbal Instructions
_____ Variable School Performance (from hour to hour/day to day)
_____ Reverses Letters, Words, or Numbers in Writing
_____ Shows Confusion About Right or Left
_____ Directional Orientation

V. Physical Development: At what age in years and months did your child:
Speak words clearly____________________Start to crawl___________________Walk Unaided_________________

Which phrase describes the child's physical maturity (please circle number)?

1 - Physically immature for age 2 - Average physical maturity for age 3 - Advanced physical maturity for age

VI. School Progress: Rate your child's progress in the following subjects:
1 - Below grade level 2 - Grade level 3 - Above grade level

_____ Reading
_____ Art
_____ Spelling
_____ Physical Education
_____ Writing
_____ Arithmetic
_____ Other____________________________________

What specific type(s) of work is your child having trouble with? ____

Have other family members had difficulties learning in any of the above areas? No______ Yes______
If yes, state relationship to child and areas of difficulty:____

Does your child have memory difficulties? No______ Yes______ If so, what type of information?

VII. General History: Is there a history of pregnancy or birth complications? No______ Yes______
If yes, please explain:____

Has there been any severe childhood illness, high fever, injury or physical impairment? No______ Yes______
If yes, please explain:____

Has your child received a hearing test? No______ Yes______ Date:____________
Has a hearing or speech deficiency been previously diagnosed? No______ Yes______
If yes, please explain:____

Has your child received a complete eye examination? No______ Yes______ Date:____________

Has a visual problem been diagnosed? No______ Yes______

If yes, please explain:____

Does your child have any allergies? No______ Yes______

If yes, please explain:____

Is your child currently taking any medications or pills? No______ Yes______

If yes, please list the medications, their purposes and duration:____

____

Has your child previously taken medication for hyperactivity? No______ Yes_______

VII. Therapy: Has there been any previous therapy for learning difficulties or visual or speech problems?

No______ Yes______

If yes, please state the type of therapy, duration and results:____

____

____

____

Signature:____Date:_______________

Relationship to child:____

Comments:____

____

____

____

____

____

____