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	INSURANCE
Date _____	Who is responsible for this account? _____
Patient _____	Relationship to Patient _____
Address _____	Insurance Co. _____
_____	Group # _____
City State Zip	Is patient covered by additional Insurance? [ ] Yes [ ] No
Email _____	Subscriber Name _____
Sex: [ ] M [ ] F Age _____ Birthdate _____	Birthdate _____ SS# _____
	Relationship to Patient _____
Patient SS# _____	Insurance Co. _____
Occupation _____	Group # _____
Employer _____	ASSIGNMENT AND RELEASE
Employer Phone # _____	I, the undersigned, certify that I (or my dependent) have insurance coverage with
Employer Address _____	_____and assign directly to Hospitality Eyecare Center all insurance
Spouse's Name _____	benefits, if any, otherwise payable to me for services rendered. I understand that I am
Birthdate _____ SS# _____	financially responsible for all charges whether or not paid by insurance. I hereby authorize
Occupation _____	the doctor to release all information necessary to secure the payment of benefits. I authorize
Spouse's Employer _____	the use of this signature on all insurance submissions.
Whom may we thank for referring you? _____	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	ALLERGIES
List medications you are currently taking, including eye drops, over the counter medications & herbs:	List your allergies to medication or other substances:
_____	_____
_____	_____
_____	_____
Pharmacy Name _____	_____
Phone _____	_____

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?

Do you use a computer more than 30 minutes a day? [ ] Yes [ ] No

Do you wear sunglasses with UV protection? [ ] Yes [ ] No

Are you interested in Contact Lenses? [ ] Yes [ ] No

Are you interested in Lasik? [ ] Yes [ ] No

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
Burning Eyes	[ ] Yes [ ]No	Itching Eyes	[ ] Yes [ ]No
Cataracts	[ ] Yes [ ]No	Light Sensitivity	[ ] Yes [ ]No
Poor Color Vision	[ ] Yes [ ]No	Loss of Vision	[ ] Yes [ ]No
Crossed Eyes	[ ] Yes [ ]No	Migraine Headaches	[ ] Yes [ ]No
Discharge from Eyes	[ ] Yes [ ]No	Poor Night Vision	[ ] Yes [ ]No
Dizzy Spells	[ ] Yes [ ]No	Red Eyes	[ ] Yes [ ]No
Double Vision	[ ] Yes [ ]No	Seeing Halos	[ ] Yes [ ]No
Dry Eyes	[ ] Yes [ ]No	Seeing Flashes	[ ] Yes [ ]No
Eye infection	[ ] Yes [ ]No	Temporary Loss of Vision	[ ] 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

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

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

COMPUTER VISION INFORMATION

Name_____
Contact Number_____
Date_____

Please identify any symptoms you experience. Comments on the change on the severity and frequency of occurrence are helpful. All information noted below will be kept strictly confidential and is subject to HIPPA privacy laws.

VISUAL
_____ Blurred vision
_____ Slow refocusing
_____ Frequent loss of place
_____ Doubling of vision
_____ Squinting
_____ Changes in color perception

OCULAR
_____ Irritated or sore eyes
_____ Itching and burning eyes
_____ Excessive tearing
_____ Dry eyes
_____ Contact lens discomfort
_____ Sore or hurting eyes

GENERAL
_____ Eyestrain
_____ Headache
_____ Eye fatigue
_____ Tired eyes

LIGHT
_____ Flickering sensations
_____ Glare
_____ Light sensitivity

MUSCLE
_____ Neck or shoulder tension or pain
_____ Back pain
_____ Pain in arms, hands, wrists or shoulders
_____ Hip, leg, ankle or foot pain

OTHER
_____ Tension
_____ Excessive physical fatigue
_____ Irritability
_____ Increased nervousness
_____ More frequent errors
_____ General fatigues or drowsiness

Please briefly answer the following questions:

How many hours per day do you work at the computer?_____

How many computer screens do you use at your work area?_____

How long can you use your computer(s) before symptoms occur?_____

_____

How long ago did you notice symptoms first occurring?_____

_____

Do your symptoms persist when you are not working? If YES, please describe._____

_____

Do you currently wear glasses and/or contact lenses for your computer work?_____

_____

Is your prescription eyewear specialized for computer use? Or is it general distance and near vision full-time wear?

_____

Have you had any eye surgeries?_____

_____

Have you had any eye diseases?_____

_____

How long ago was your last complete vision examination?_____

_____

How long ago was your last complete medical examination?_____

_____

Some medications have ocular side-effects. Do you currently take any medications? If so, please list._____

_____

Are there any specific concerns or questions you have regarding the ergonomics of your work area?_____

_____

Are there any specific concerns or questions you have regarding your eyes in relation to your work environment and computer use?_____

_____

Are there any other concerns or questions you would like Dr. Corbett to be aware of?_____

_____

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

LIFESTYLE QUESTIONAIRE

Name_____Date_____

Contact Number_____

To better meet your visual needs, the doctor would like to know which activities you participate in.
Please check all that apply.

_____ Bowling
_____ Golf
_____ Tennis
_____ Fishing
_____ Flying
_____ Driving
_____ Hunting
_____ Exercise
_____ Playing musical instruments
_____ Pottery Making
_____ Travel

_____ Sewing/arts and crafts
_____ Bookkeeping
_____ Computer use
_____ Reading
_____ Boating
_____ Playing cards
_____ Biking
_____ Video gaming
_____ Writing
_____ Painting

Are you satisfied with your distance and reading vision? Yes_____ No_____

Are you satisfied with your present frames and type of lenses? Yes_____ No_____

Do you wear sunglasses? Yes_____ No_____

Does the glare from headlights bother your eyes? Yes_____ No_____

Are you interested in information on LASIK refractive surgery? Yes_____ No_____

How many hours a day do you operate a computer? _____