EyeQ Optometry
Patient Information Form

SECTION A: Basic Information

Name

Prefix | First Name | MI | Last Name

Preferred Pronouns

Birthdate (MM/DD/YYYY)

Address

Street / Unit #

City | State | Zip Code

Primary Phone

(CIRCLE ONE) Home/Landline or Mobile/Cell

Email Address

Emergency Contact

Name | Relationship | Phone Number

EyeQ Optometry
4193 24th St, San Francisco, CA 94114
P 415-821-3937 F 415-821-5896
eyeq1@pacbell.net

EyeQ Optometry
Patient Information Form

SECTION B: Medical Information

I currently wear (*circle all that apply*):

Glasses Soft Contact Lenses Rigid Gas Permeable Nothing

I would like to wear (*circle all that apply*):

Glasses Soft Contact Lenses Rigid Gas Permeable Nothing

Are you currently pregnant or nursing? *(circle one)*: Y / N

Date of last physical examination

Are you allergic to any medications or substances? *(include name and type of response)*

Please list any health conditions you have and medications you currently take:

EyeQ Optometry
4193 24th St, San Francisco, CA 94114
P 415-821-3937 F 415-821-5896
eyeq1@pacbell.net

EyeQ Optometry
Patient Information Form

SECTION B: Medical Information *(continued)*

Personal and family history (*circle any that apply and write relationship, including "self"*)

Autoimmune Disorders _____	High Cholesterol _____
Blindness _____	High Blood Pressure _____
Cataracts _____	Macular Degeneration _____
Diabetes _____	Retinal Detachment _____
Glaucoma _____	Thyroid Disease _____
Heart Disease _____	Tobacco Use *(current/past)* _____

I am aware that it is my responsibility to give 24 hours advance notice if I need to change or reschedule any appointments. A fee of $60.00 will be assessed for any missed appointments. I understand that this fee is not covered by insurance.

Initial: _____

I have read EyeQ Optometry's Notice of Privacy Policies and understand that I can print or request a copy.

Initial: _____

Patient/Guardian Signature

Date

EyeQ Optometry
4193 24th St, San Francisco, CA 94114
P 415-821-3937 F 415-821-5896
eyeq1@pacbell.net

EyeQ Optometry
Patient Information Form

SECTION C: VSP Insurance Information

If you do not have VSP, please skip this section.

We only bill directly for patients with VSP Signature and VSP Choice Plans. For other VSP plans, our office can assist you in filling out forms or providing invoices so that you can submit for reimbursement.

Legal Name of Primary Member

Last Name

First Name

Patient Relationship to Primary Member

Date of Birth of Primary Member

Last 4 digits of Primary Member's Social Security Number, or Unique ID *(if employer provided one)*

Patient/Guardian Signature acknowledging responsibility for any services ormaterials not covered by VSP

Date

EyeQ Optometry
4193 24th St, San Francisco, CA 94114
P 415-821-3937 F 415-821-5896
eyeq1@pacbell.net