SOUTHWOOD
Optometry

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WELCOME TO OUR OFFICE

PLEASE FILL OUT FORM COMPLETELY

Meaningful Use (MU) to improve the quality, safety, efficiency, and reducing health disparities

(PLEASE PRINT) Today's Date: ______________________

Title ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. Other__________

Marital Status ______________________________________

Name (First MI Last) ______________________________________

Street ______________________________________

City ______________________ State ______ Zip __________

Home Phone ______________________________________

Work Phone ______________________ Ext. __________

Mobile Phone ______________________________________

Email Address ______________________________________

Date of Birth ______________ Age ______ Sex: ☐F ☐M

Social Security Number ______________________________

Employer (or School) ______________________________

Occupation (or Grade) ______________________________

Employment Status: ☐Employed Full-Time ☐Employed Part-Time

☐Full-Time Student ☐Part-Time Student ☐Retired ☐Not Employed

Preferred Language ______________________________

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American

☐Decline to Specify ☐Hispanic or Latino ☐Native Hawaiian or Other Pacific Isl.

☐White ☐Other ______________________________________

Hobbies ______________________________________

EYE HEALTH

Date of Last Eye Exam: __________ By: __________________

What is the reason for today's visit? __________________

____

____

Do you currently wear glasses? __________________________

When do you wear your glasses?: ☐At all times

☐Driving ☐Reading ☐Computer ☐Sports

What features are important to you when choosing glasses?

☐Anti-Glare ☐Color Changing Lens ☐Weight

☐Scratch Proof ☐Material ☐Other ______________________

Do you wear contact lenses? ______________________________

What percentage of the time do you wear glasses? __________

What percentage of the time do you wear contact lenses? ________

Any problems with your present glasses or contact lenses?

____

Spectacle or Contact Lens Type __________________________

Contact Lens Solution used ______________________________

Do lights at night bother you? ___________________________

How long do you read/work at a computer each day? __________

MEDICAL HISTORY

Condition: Please check all that apply

Condition		Condition	
Allergies	☐	Arthritis	☐
Asthma	☐	Cancer	☐
Skin Disorder	☐	Diabetes	☐
Eye Disease	☐	Heart Disease	☐
Eye Injury	☐	Hypertension	☐
Eye Surgery	☐	Kidney Disease	☐
Lazy Eye	☐	Nerve Disorder	☐
Cataracts	☐	High Cholesterol	☐
Glaucoma	☐	Other ______________	

CURRENT MEDICATIONS (RX and/or Over The Counter)

(If you have a current medication list, please provide it so we can copy it for our records. Including vitamins. Thank you!)

Name/Strength/Dosage:

____

____

____

____

____

Medications Allergic to: ______________________________

____

Date Last seen by General Physician: ____________________

Name of Physician ______________________________________

Are you currently under the care of a physcian? ☐Yes ☐No

Smoking Status: ☐ Smoker ☐ Non Smoker

How often do you smoke?______________________________

Family Medical History

Condition: Please check all that applies		Relationship
Hypertension	☐	______________
Glaucoma	☐	______________
Diabetes	☐	______________
Heart Disease	☐	______________

Other ______________________________________

____

INSURANCE INFORMATION

Are you the primary member? ☐Yes ☐No

If no, please provide the following information:

Name (First & Last) ______________________________

Date of Birth ____________Last 4 of Social Security __________

Employer ______________________________________

WHO MAY WE THANK FOR YOUR REFERRAL?

☐Friend or Relative? Who? ______________________________

☐Another Health Care Provider? Who? ____________________

☐Insurance Panel? Name ______________________________

☐Other ______________________________________

AUTHORIZATION TO PAY BENEFITS TO DR. MATSUNAGA:

I hereby authorize payment directly to the Doctor for benefits otherwise payable to me for services: I understand that I am responsible for the balance not paid by insurance.

Any balance of 30 days or more will incur a finance charge of 1.5% per month.

Signature: ______________________Date: ______________