ST. HELENA OPTOMETRY
MATTHEW R. HILEMAN, O.D. 1104 ADAMS STREET, SUITE 101 ST. HELENA, CA 94574 (707) 963-7923

PLEASE PRINT ALL INFORMATION

PATIENT INFORMATION

DATE _____

Patient Name _____ □ Mr. □ Mrs. □ Ms. □ Miss □ Dr.
(Last) (First) (MI)

Preferred Name _____ Date of Birth ___/___/___ Age _____ Gender □ Male □ Female

Home Address _____
(Street) (City) (State) (Zip)

Mailing Address _____
(Street) (City) (State) (Zip)

Phone (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
(Home) (Work) (Cell)

Employer _____ Occupation _____

Whom may we thank for referring you to our office? _____

FINANCIALLY RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name _____ □ Mr. □ Mrs. □ Ms. □ Miss □ Dr.
(Last) (First) (MI)

Preferred Name _____ Date of Birth ___/___/___ Age _____ Gender □ Male □ Female

Home Address _____
(Street) (City) (State) (Zip)

Mailing Address _____
(Street) (City) (State) (Zip)

Phone (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
(Home) (Work) (Cell)

Employer _____ Occupation _____

PRIMARY VISION INSURANCE

Name of Policy Holder _____ Date of Birth ___/___/___
(Last) (First) (MI)

Social Security/Member ID # _____ Relationship to Patient _____

Name of Insurance Co. _____ Phone of Insurance Co. (_____) _____-_____

Plan Name _____ Group # _____ Effective Date ___/___/___

Address of Insurance Co. _____
(Street) (City) (State) (Zip)

SECONDARY VISION INSURANCE

Name of Policy Holder _____ Date of Birth ___/___/___
(Last) (First) (MI)

Social Security/Member ID # _____ Relationship to Patient _____

Name of Insurance Co. _____ Phone of Insurance Co. (_____) _____-_____

Plan Name _____ Group # _____ Effective Date ___/___/___

Address of Insurance Co. _____
(Street) (City) (State) (Zip)

FINANCIAL POLICY

In an effort to better serve our patients and keep costs to a minimum, our office maintains the following financial policy:

- Payment for all exam types is due at the time of service.
- Payment for all materials (glasses and contact lenses) is due at the time of order placement.
- Exceptions to this plan are considered only on a case-by-case basis. When exceptions occur, accounts overdue in excess of 30 days shall incur a finance charge of 1.5% of the outstanding balance. Overdue accounts in excess of 90 days may be subject to referral to a collection agency.
- Accepted forms of payment include cash, check, Visa, and MasterCard.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY OFFERED TO ME THROUGH THE OFFICE OF MATTHEW R. HILEMAN, O.D., ST. HELENA OPTOMETRY.

Patient Signature _____ **Date** _____
** A parent's signature is required for patients under the age of 18 years.*

AUTHORIZATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR INCIDENTAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS FOR ANY SERVICES RENDERED TO ME BY, OR UNDER THE SUPERVISION OF, MATTHEW R. HILEMAN, O.D., ST. HELENA OPTOMETRY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

Patient Signature _____ **Date** _____
** A parent's signature is required for patients under the age of 18 years.*

I AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS TO MATTHEW R. HILEMAN, O.D., ST. HELENA OPTOMETRY FOR SERVICES RENDERED TO ME BY HIM OR UNDER HIS SUPERVISION.

Patient Signature _____ **Date** _____
** A parent's signature is required for patients under the age of 18 years.*

FOR OFFICE USE ONLY

Verification of information/update of changes

Staff Initials _____ Date _____ Nature of change _____

Staff Initials _____ Date _____ Nature of change _____

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MEDICAL HISTORY
PLEASE PRINT ALL INFORMATION **DATE** _____

Although eye care professionals primarily treat the eyes and their associated structures, your eyes are part of your entire body. Health problems that you may have, or medication that you may be taking, could have a significant effect on your eyes and the treatment that you will need to receive. Likewise, your lifestyle, hobbies, or occupation could influence the recommendations for your glasses and/or contact lens prescription. Thank you for answering the following questions.

Name _____ Date of Birth ____/____/____ Gender □ Male □ Female

Date of last eye exam _____ Do you currently wear glasses? □ Yes □ No Physician _____

OCULAR HISTORY

Contact Lenses

Do you wear contact lenses? □Yes □ No If not, would you like to wear contact lenses? □ Yes □ No

Type of contact lenses □ Disposable Soft Lenses □ Standard Soft Lenses □ Rigid Lenses

If you use disposable lenses, how often do you throw them away? _____

What solutions do you use? _____

Do you ever sleep while wearing your contact lenses? □ Yes □ No How often? _____

Surgery

Have you ever had refractive surgery? □ Yes □ No If yes, specify type □ RK □ PRK □ LASIK

Are you interested in refractive surgery? □ Yes □ No

Ocular Health

Do you have, or have you ever had, problems with any of the following? (Please check all that apply.)

	Yes	No		Yes	No
Blurred Vision	□	□	Distorted Vision/Halos	□	□
Peripheral Vision Loss	□	□	Double Vision	□	□
Dryness	□	□	Mucous Discharge	□	□
Sandy/Gritty Feeling	□	□	Itching	□	□
Burning	□	□	Eye Trauma/Injury	□	□
Flashes	□	□	Tired Eyes	□	□

SOCIAL HISTORY

Do you use tobacco products? □ Yes □ No If yes, state type/amount/how long _____

Do you drink alcohol? □ Yes □ No If yes, state type/amount/how long _____

PERSONAL/FAMILY HISTORY

List any medications you are currently taking _____

List any allergies to medicines you have _____

Are you currently pregnant or nursing? □ Yes □ No Are you allergic to latex? □ Yes □ No

PERSONAL/FAMILY HISTORY (CONT.)

Do you or an immediate family member (parents, grandparents, siblings, children) currently have, or have ever had, any of the following? (Please check all that apply.)

	You		Family		How are they related to you?
	Yes	No	Yes	No	
Blindness/loss of vision	□	□	□	□	_____
Crossed eyes	□	□	□	□	_____
Glaucoma	□	□	□	□	_____
Macular Degeneration	□	□	□	□	_____
Retinal Detachment	□	□	□	□	_____
Retinal Disease	□	□	□	□	_____
Cancer	□	□	□	□	_____
Diabetes	□	□	□	□	_____
Heart Disease	□	□	□	□	_____
High Blood Pressure	□	□	□	□	_____
Other _____	□	□	□	□	_____

REVIEW OF SYSTEMS

Do you currently have, or have you ever had, problems with any of the following? (Please check all that apply.)

	Yes	No		Yes	No
Fever/Weight Loss	□	□	Vascular Disease	□	□
Skin Problems	□	□	High Cholesterol	□	□
Headaches	□	□	Chronic Diarrhea	□	□
Allergies/Hay Fever	□	□	Kidney/Bladder Func.	□	□
Dry Throat/Mouth	□	□	Blood Disorder	□	□
Asthma	□	□	Other _____	□	□
Rheumatoid Arthritis	□	□			

PATIENT LIFESTYLE

Do you have any children? □ Yes □ No If yes, how many? _____ What are their ages? _____

Please check activities in which you participate

□ Reading	□ Golf	□ Fishing
□ Movies/plays	□ Baseball/softball	□ Hunting
□ Watching TV	□ Tennis	□ Camping
□ Card or board games	□ Racketball/handball	□ Hiking/backpacking
□ Play musical instrument	□ Paintball	□ Painting/drawing
□ Sewing/needlework	□ Soccer	□ Photography

Are you interested in receiving information about sports or safety eyewear? □ Yes □ No

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

The information listed above was reviewed and updated

Provider _____ Date _____ Changes _____

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