

Optometric Images - Vision Center
Dr. Gary K. Ozaki - Dr. Randall S. Ramsey
Welcome to Our Office

Today's Date: _____

General Information

Last Name _____ First Name _____ MI _____ Sex *M / F*
If minor, list parents names _____
Address _____ City _____ State _____ Zip _____
Work Phone (____) _____ Home Phone (____) _____ SSN _____
DOB _____ Occupation _____ Employer _____
Emergency Contact Name _____ Phone Number _____
Referred by: *Yellow Pages Mailer Friends/Family Walk-by Insurance List Other* _____

Personal Eye Information

Date of Last Exam _____ Name of Doctor _____ Last Year of eye dilation _____
Reason for today's visit? *Routine Exam CL Exam Medical Condition*
Have you had any eye operations? *Yes / No* Type _____ Date _____
Have you had an eye injury? *Yes / No* Kind _____ Date _____
Do you have Glaucoma? *Yes / No* Cataracts? *Yes / No* Dry Eyes? *Yes / No*
Macular degeneration? *Yes / No* Retinal detachment? *Yes / No* Blurred Vision? *Yes / No*
Do you wear glasses? *Yes / No* Contact Lenses? *Yes / No* If yes, *Soft / Hard*
Do you work on computers? *Yes / No* Hours per day? _____
Additional Information: _____

Personal Medication Information

How is your general health? _____
Do you have high blood pressure? *Yes / No* Diabetes? *Yes / No*
Current Medications? _____
Allergies to Medications? *Yes / No* Which? _____
General Allergies? (ex. Pollen) *Yes / No* Do you suffer from dry eyes? *Yes / No*
Are the allergies causing redness, itching, or watery eyes that you need treated? *Yes / No*
Do you smoke? *Y / N* Alcohol? *Y / N* Other substances? *Y / N*

Family History

HBP? *Y / N* Relation _____ Macular Degeneration? *Y / N* Relation _____
Diabetes? *Y / N* Relation _____ Retinal Detachment? *Y / N* Relation _____
Glaucoma? *Y / N* Relation _____ Cataracts? *Y / N* Relation _____

Insurance / Payment

Do you have eye insurance? *Y / N*
Type: *VSP MES AVP EyeMed Medicare Davis Spectera Other:* _____
MAJOR MEDICAL INS: _____ ID# _____
Primary's Employer
Name: _____
Primary's Name: _____ SSN: _____ DOB: _____

Payment is expected at the time of services