EyeMazing Optical

Gerardo R Noriega OD

Call: (210) 545-5755
Fax: (210) 545-5855

Basic Info.

Name_____ DOB____/____/____ SSN_____-_____-_____
Last First MI

Address_____
City State Zip

Circle best. Home_____ Work_____ Cell_____

Email_____ Driver's License_____
Expiration State

☐single ☐married ☐divorced ☐other Have you been here before? ☐yes ☐no *If yes, when?*_____

Employed: ☐F/T ☐P/T ☐Student ☐Child ☐N/A Employer_____ Occupation_____

Reason for visit: ☐eye exam ☐contact lens exam ☐emergency ☐other_____

Interested in: ☐Dilation *$19 fee* ☐Laser vision ☐Corrective Lens Therapy *corrects vision while you sleep* ☐other_____

Has anyone with the same mailing address been here before? If yes, name_____

How did you hear about us? ☐Ad ☐Insurance ☐Drove by ☐Internet ☐Phone Book ☐Other_____

Who do we thank? ☐Family/Friend_____

Insurance.

Vision Insurance_____ Member ID_____ Employer_____

Primary Member_____ Primary SSN_____-_____-_____

Health History.

	You	Family	
1.	☐	☐	blindness
2.	☐	☐	cataracts
3.	☐	☐	diabetes
4.	☐	☐	eye disease/surgery
5.	☐	☐	glaucoma
6.	☐	☐	heart disease
7.	☐	☐	hypertension
8.	☐	☐	lazy eye/double vision
9.	☐	☐	pulmonary condition
10.	☐	☐	thyroid disease
11.	☐	☐	other_____
12.	☐		allergies
13.	☐		dry/itchy eyes
14.	☐		eye/head injury
15.	☐		eye strain
16.	☐		floaters
17.	☐		headaches
18.	☐		light flashes
19.	☐		light sensitivity
20.	☐		temporary vision loss
21.	☐		watery eyes

	Yes	No	
22.	☐	☐	smoker
23.	☐	☐	alcohol user
24.	☐	☐	substance abuser
25.	☐	☐	risk of eye injury
26.	☐	☐	currently on medication
27.	☐	☐	medical allergy

If yes to any, please explain here:

Authorization of Payment.

I, _____ hereby authorize payment directly to Dr Noriega to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all services rendered on my behalf and/or for any dependents.

Signature of Responsible Party _____ Date_____

Notice of Privacy Practices: I acknowledge that I have received information on Dr Noriega's Note of Privacy Matters.

Signature of Responsible Party _____ Date_____