Welcome To Our Office

Dr. Claudia L. Chavez O.D.
Board Certified Optometric Physician

Date: ___/___/_____

Patient Name: _____
Address: _____
City: _____ State:_____ Zip:_____
DOB: ___/___/_____ Sex: M___ F___ Email: _____
Home Phone: _____ Cell Phone: _____
Employed By: _____ Occupation: _____

Insurance:
Our office is not a provider for all eye insurance plans. Please provide your insurance card at time of service to see if we are in network with your plan.
Name of Primary Insurance:_____
ID or Group #: _____
Name of Secondary Insurance: _____

Do you currently wear eyeglasses: (___)Yes **OR** (___)No

Are you having any problems with your vision?
( ) Far Away ( ) Close Up
( ) In Between

When do you have problems with bright lights or glare?
( ) Day ( ) Night
( ) On-coming headlights
( ) Computer Screen
( ) Glare from windshield
( ) Sunlight

What do you like (Y) dislike (N) about your current eyewear?
( )Weight ( )Thickness ( )Fit
( )Shape ( )Durability ( )Size
( )Style ( )Color

Do you currently wear Contacts: (___)Yes **OR** (___)No

Do you have a backup pair of Eyewear?
(___)Yes **OR** (___)No

What do you like (Y) dislike (N) about your contacts?
( )Vision ( )Comfort
( )Dryness ( )Itch

When do your contacts feel dry?
_____

How often do you sleep with your contacts in?
_____

Have you ever had cataract surgery: _____

Have you had any injury, or medical treatments to the eye within the last year:
_____

Daily medications are: _____

How did you hear about us:(___) Phone Book (___) Walk-In (___) Internet (___) Radio

Would you like to be dilated: (___) Yes (___) No (___) At another time
During the health inspection of your eyes it may be necessary to dilate your pupils to get a better view of the back of your eye. (Including the retina, optic nerve and blood vessels.) Afterward, your vision will become blurred and will remain light sensitive for several hours. We recommend that you wear sunglasses or dark glasses of some type and may need someone to drive you home. You can voluntary decline this procedure or schedule it for a later date.

Signature:_____
Parent name and signature if under 18 years old.

All services are to be paid at the time of appointment.

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HIPPA

Health Insurance Portability and Accountability Act
Notice of Privacy Practice (NPP)
Claudia L. Chavez, O.D.

DISCLOSURE:

We will not disclose your records without your written authorization except to:

- You
- Your legal representative
- The Department of Heath pursuant to existing law
- In the event you are incapacitated or unable to request your records, your spouse.
- In any civil or criminal proceedings upon the issuance of a subpoena from a court jurisdiction and proper notice to you or your legal representative, by the party seeing the records.
- Inquires may be directed to the privacy officer, Claudia L. Chavez, O.D.

Signature: _____ Date: _____

(Parent name and signature if patient is under 18 years old)

Print Name: _____