

# Glendale Optometric Center & Carl S. Shibata, M.D.

**Patient's Name** \_\_\_\_\_ **Today's Date** \_\_\_\_\_  
 Dr. Mr. Mrs. Ms. Miss \_\_\_\_\_  
 Address \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Ext. \_\_\_\_\_  
 Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Email Address \_\_\_\_\_  
 Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_  
**Employer (or school)** \_\_\_\_\_ **occupation (or Grade)** \_\_\_\_\_

**Vision Insurance**  
 Primary \_\_\_\_\_ Subscriber \_\_\_\_\_ Member ID# \_\_\_\_\_  
 Secondary \_\_\_\_\_ Subscriber \_\_\_\_\_ Member ID# \_\_\_\_\_

**Medical Insurance (Provide Insurance Cards)**  
 Primary \_\_\_\_\_ Subscriber \_\_\_\_\_ Member ID# \_\_\_\_\_  
 Secondary \_\_\_\_\_ Subscriber \_\_\_\_\_ Member ID# \_\_\_\_\_

**Parent or Person Responsible for account** \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security Number \_\_\_\_\_

**In Case of Emergency, Contact:**  
 Name \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Current Medications**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergy to Medications**  
 \_\_\_\_\_

**Personal/Family Medical History**

Cardiovascular	No	Yes	Glaucoma	No	Yes
Ear/Nose/Throat	No	Yes	Cataracts	No	Yes
Respiratory	No	Yes	Macular Degeneration	No	Yes
Gastrointestinal	No	Yes	Eye Injury	No	Yes
Genitourinary	No	Yes	Retinal Tear/Detachment	No	Yes
Arthritis/Muscular	No	Yes	Blindness	No	Yes
Skin Disorders	No	Yes	Amblyopia/Strabismus	No	Yes
Neuro/Psychological	No	Yes	Eye Surgery	No	Yes
Diabetes	No	Yes	Corneal Ulcer/Abrasion	No	Yes
Thyroid	No	Yes	Bleeding Tendency	No	Yes
Cancer	No	Yes	Headaches	No	Yes
High Blood Pressure	No	Yes	Dry Eyes	No	Yes

Other \_\_\_\_\_  
 Do you use Cigarettes/Tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_  
 Other Substances? \_\_\_\_\_  
 Name of Family Physician \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_

Were you dilated? Yes No

Do you have trouble reading signs at night? Yes No

Do you have trouble with bright sunlight? Yes No

Do you have prescription sunglasses with UV protection? Yes No

Do your eyes burn, itch or tear excessively? Yes No

How many hours a day do you spend on a computer? \_\_\_\_\_

How many hours a week do you spend outdoors? \_\_\_\_\_

Do you wear contact lenses? Yes No

What kind? \_\_\_\_\_  
 Solutions? \_\_\_\_\_

Are you interested in contact lenses? Yes No

Are you interested in Lasik surgery? Yes No

How do you use your eyes for work? \_\_\_\_\_  
 \_\_\_\_\_

How do you use your eyes for hobbies? \_\_\_\_\_  
 \_\_\_\_\_

I authorize the release of payment for Medical benefits directly to **Glendale Optometric Center** and the release of any medical information necessary to process all insurance claims.

I understand that the dilating eye drops used as part of the examination may blur vision for an hour or longer and make it unsafe to drive. I will not attempt to drive until I feel safe to do so.

I acknowledge that I am responsible for payment of all services and materials in the event that my insurance denies any claims.

Patient's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_