Welcome To Our Office

Jon H. Yamane, O.D., Inc.
1545 Nutmeg Place, Costa Mesa, CA 92626

Name: _____ Today's Date: _____/_____/_____

Address: _____ Cell Phone: _____

_____ Email: _____

Birthdate:_____/_____/_____ Social Security #: _____-_____-_____

Insurance: _____ Policy Number: _____

Occupation: _____ Hobbies:_____

Name of spouse &/or children: _____

Family members in household: _____

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

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Notice of Privacy Practices

Acknowledge of receipt

I acknowledge that I received a copy of Jon H. Yamane, O.D., Notice of Privacy Practices.

Patient Signature: _____ Date: _____
(Sign Here)

A copy of the Notice of Privacy Practices for this office can be obtained at:
18685 Main Street, Suite 105, Huntington Beach, CA

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Insurance Authorization

I request that payment of authorized insurance benefits for any services provided to me be made on my behalf to:
Jon H. Yamane, O.D.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits payable for related services.

I understand that the quote of benefits by the insurance company is not a guarantee of payment.

I understand that I am responsible for charges not paid by the insurance company.

X _____ _____
Signature Date

Turn over

Medical History Questionnaire

Name of Medical Doctor: _____ Last Medical Exam Date: _____

Medical History
Do you have any allergies to medications? □ No □ Yes If yes, please explain _____

List any medications you take: _____

_____

List all major injuries, surgeries, or hospitalizations: _____

_____

Are you pregnant and/or nursing? □ no □yes If yes, what trimester are you in? _____

Do you wear glasses? □ no □yes If yes, how old are your present pair of lenses? _____
Do you wear contact lenses? □ no □yes If yes, how old is your present pair of lenses? _____

Type of Contact Lens & Solution used: _____

If yes, how often do you replace your lenses? _____

Family Ocular History:
List any family history of ocular disease and their relationship to you: □none_____

_____

Family Medical History:
List any family history of medical disease and their relationship to you: □none_____

_____

Social History:
Do you use tobacco products? □ no □yes If yes, type/amount/how long: ___
Do you drink alcohol? □ no □yes If yes, type/amount/how long:_____
Do you use illegal drugs? □ no □yes If yes, type/amount/how long:_____

Have you ever been infected with any sexually transmitted disease: □None _____

Review of Systems
Do you currently, or have you ever had any problems in the following areas:

Weight loss/gain: □ no □yes _____
Neurological (headaches, migraines, etc.) □ no □yes _____
Eyes (blur, dryness, redness, glare, flashes, floaters): □ no □yes _____
Endocrine (thyroid): □ no □yes _____
Ears, nose, mouth, throat: □ no □yes _____
Respiratory (asthma, bronchitis, emphysema, etc.): □ no □yes _____
Cardiovascular (diabetes, high blood pressure) □ no □yes _____
Gastrointestinal □ no □yes _____
Bones / Joints / Muscles: □ no □yes _____
Lymphatic/ Blood: □ no □yes _____
Allergic / Immunologic: □ no □yes _____
Psychiatric: □ no □yes _____
Other: □ no □yes _____

Date Reviewed_____Dr's Signature_____,O.D. Turn over