WELCOME TO RICHARD H MARCUS OD
510-523-6339

Please take a moment to complete the following information.
If you have any questions, please ask us.

Patient Information

□ Mr. □ Mrs. □ Ms. □ Child □ Male □ Female

First Middle Last Preferred Name

Address: _____ City: _____ State _____ Zip: _____

Social Security# ___/___/___ Date of Birth: ___/___/___

Email Address _____ (only for office communication, we respect your privacy)

Phone: Cell:(___) _____ Home: (___) _____

May we contact you via Text for appointment confirmation? Y___ N___ (Standard text message charges may apply)

Whom may we thank for referring you? _____

Primary Insurance Information: Vision Insurance: □ VSP □ EYEMED □ MEDICARE □ Other _____

Who is Policy Holder (Insured)?: □ Self □ Spouse □ Child □ Domestic Partner □ Other

Patient's Status: □ Single □ Married □ Child □ Employed □ Full Time Student □ Other

Insured's Name: _____
First Middle Last

Insured's Employer _____ Primary Medical Insurance

Insured's Medical ID No.: _____ Group No.: _____ Date of Birth: ___/___/___

Insurance Company Phone No.: (___) _____

Insured's Phone No.:(___) _____ □ Home □ Cell

Secondary Insurance Information: Vision Insurance: □ VSP □ EYEMED □ MEDICARE □ Other _____

Who is Policy Holder (Insured)?: □ Self □ Spouse □ Child □ Domestic Partner □ Other

Secondary Insured's Name: _____
First Middle Last

Secondary Insured's Employer _____ Secondary Medical Insurance _____

Secondary Insured's Medical ID No.: _____ Group No.: _____

Secondary Insured's Date of Birth: ___/___/___

Secondary Insurance Company Phone No.: (___) _____

Secondary Insured's Phone No.:(___) _____ □ Home □ Cell

PAYMENT TERMS: See attached form.

I have read and agree to the attached provisions of the office financial policy.

Dated: _____ x _____
Patient's Signature

HEALTH HISTORY QUESTIONNAIRE

Your Primary Care Physician _____ Physician's Tel:_____

When was your last *Health* exam?_____ When was your last *Eye* exam?_____

□ Male □ Female

History of Major Illnesses/Injuries

History of Surgeries	Date	Surgeon
Eye:		
Other:		

Current Medications & Eyedrops	Reason for Taking

DRUG ALLERGIES	

Your Current Eye Symptoms	Yes	No
Glaucoma		
Cataract		
Macular degeneration		
Retinal detachment		
Color Blindness		
Headaches		
Glare/light sensitivity		
Tired eye		
Lazy eye		
Burning		
Dryness		
Excess tearing		
Eye pain or soreness		
Foreign body sensation		
Infection of eye		
Itching		
Mucous discharge		
Droopy eyelid		
Redness		
Sandy or gritty feeling		
Crossed eyes		
Blurred vision distance		
Blurred vision near		
Distorted Vision		
Double Vision		
Floaters or spots		
Fluctuating Vision		
Loss of Vision		
Loss of Side Vision		

Your Medical History	Yes	No
Allergies (seasonal)		
Excessive Weight Loss/Gain		
Ears, nose, throat		
High Blood Pressure		
High Cholesterol		
Asthma/Breathing Problems		
Stomach Problems		
Arthritis/Osteoporosis		
Skin (acne, rashes, etc.)		
MS/Seizures		
Anxiety, depression		
Kidney Problems		
Diabetes		
Thyroid Problems		
Anemia/Blood Disorders		
HIV/Herpes/Lyme		
Cancer: type:		
Other specify		
Are you pregnant/nursing?		

Your Family History Eye Diseases	Yes	No	Who
Lazy eye			
Eye tumor			
Blindness			
Cataract(s)			
Color Blindness			
Glaucoma			
Macular degeneration			
Retinal detachment			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Stroke			
Kidney Disease			
Lupus			
Thyroid Disease			
Other:			

Your Social History	
Current Occupation:	
Computer Use? Y or N Hrs/Day:	Exercise? Y or N Times per Week:
Do you wear glasses? Y or N If Yes: Full time or Part time? Type of glasses owned:	Do you use vitamins? Y or N Drink Alcohol? Y or N Drinks per week:
Do you wear contacts? Y or N If yes: what type	Smoke? Y or N 1/2/Pk 1/Pk 1+/Pk Day/Week
Hobbies/Interests (Circle): Golf/Tennis/Baseball/Fishing/Hiking/Jogging/Other:	

Patient Signature: x_____ Print Name: _____ **Date:**_____

Date	Changes Y/N	PT Initial	Date	Changes Y/N	PT Initial	Date	Changes Y/N	PT Initial