California Avenue Optometry
& Contact Lens Clinic
456 S. California Avenue
Palo Alto, CA 94306

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Welcome To Our Office !

Today's Date _____ Referred by _____

Please Check Where Applicable: □ Vision Service Plan (VSP) □ EyeMed (EM) □ Other
□ Medical Eye Services (MES) □ Medicare _____

Last Name _____ First _____M.I._____

Home Address _____ City _____ State_____ Zip _____

Phone (H) (_____)_____ Day (_____)_____ Cell (_____)_____

Birth Date _____ Age _____ Sex □ M □ F Social Security Number _____-_____-_____

If under 18 years old, Parent or Responsible party's Name & Phone _____

Occupation _____ Employer_____

Spouse's Name / Occupation _____ Emergency Contact / Phone _____

Favorite Activities / Special Interests _____

Personal and Family Eye / Ocular History

Name of Previous Eye Doctor _____ City _____ Date of last Eye exam _____

Do you wear: Prescription Eyeglasses or Sunglasses? □ Yes □ No Are you comfortable with them? □ Yes □ No
Contact Lenses? □ Yes □ No Type _____ Are you comfortable with them? □ Yes □ No

Are you interested in: New Eyeglasses today? □ Yes □ No □ Only if I need them, or if my prescription changes
Contact Lenses today? □ Yes □ No □ Only if I need them, or if my prescription changes
Obtaining information on wearing Contact Lenses □ Yes □ No

Personal history of Eye Injury, Surgery, or Eye problem (Glaucoma, Cataracts, Retinal Detachment, Macular Degeneration, Diabetic Eye Disease, etc.)? _____

Family History of Eye Disease, Surgery, or Eye problem? _____ Relation _____

Personal and Family Health History

Are you in good health □ Yes □ No Are you under a Doctor's care or receiving treatment for any eye or medical condition?

□ Yes □ No Please describe _____

Name of Family Doctor _____ City _____ Date of last Medical exam _____

Personal History of High Blood Pressure (Hypertension), Heart problems, Diabetes, Stroke, High Cholesterol, Systemic Disease, or any other significant medical problem? _____

Family History of Medical Problems mentioned above? _____Relation _____

Medications / Pills / or Eye Drops currently used _____

Allergies to any Substance, Medication, Pill, or Eye Drop _____

I acknowledge that I have received a copy of California Avenue Optometry's HIPAA Compliance NOTICE OF PRIVACY PRACTICES: Signature _____ Date _____

Payment is requested at time of services: We accept Cash, Checks, VISA, or Master Card for your convenience