Name: _____ Date of birth: _____ Occupation: _____

Address: _____ Zip Code: _____

Cell: _____ Landline: _____

Email: _____

We will never sell or give out your email. This is for your electronic health record and reminder system

May we send you appointment reminders by **TEXT** Yes No **EMAIL** Yes No **Phone** Yes No

Please circle if you have a history of any of the following *eye problems* **NONE**

Eye Surgery Cataracts Eye Injury Glaucoma Lazy Eye other: _____

Please circle if you currently have any problems in the following areas or circle none. NONE

Constitutional (fever, weight gain/loss)	Cardiovascular	Integmentary (skin)	Diabetes	Endocrine (thyroid etc)
Neurological (headaches, seizures, etc)	Heart Disease	Ears, nose throat	Cancer	Allergic/immunologic
Respiratory (asthma, bronchitis, etc)	Genio/Unrinary	Hypertension	HIV/AIDS	Bones, joints, muscles
Psychiatric (depression, anxiety, etc)	Gastrointestinal	Lumphatic/Hematologic (anemia etc)		

Do you use any medications? YES NO If yes, please list:

_____ _____ _____

Do you have any allergies to medications? YES NO If yes, please list:

_____ _____ _____

Have you had surgery to any part of your body? YES NO **Females, are you pregnant or nursing?** YES NO

Has anyone in your family had any eye diseases? YES NO

A **Dilation** is a procedure where drops are put into your eyes to enlarge the pupils and allows the most thorough examination of the back of your eyes. It is possible to examine your eyes without a dilated exam, but a problem affecting the health of your eyes might not be detected if you refuse the procedure. It is recommended that all patients have a dilated exam. A dilated exam does take longer (about an hour) and you will have blurred vision and light sensitivity for approximately 4-6 hours. A driver is recommended to take you home when you are dilated.

After reading the above: _____ I request _____ I refuse or _____ I would like to return for a dilated exam

Please list any persons with whom we may discuss your health information. This authorization is optional and may be withdrawn at any time.

_____ _____ _____

_____ _____ _____

I acknowledge that I have been offered a copy of the Notice of Privacy Practices of AVS and that all the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Insured Person is: Self Parent Spouse Name (if not patient): _____ Date of birth: _____

I authorize Alvarez Vision Services, INC/Dr Michael Alvarez to bill my insurance and authorize the release of information necessary to process the claim. I understand that I wll be responsible and billed for any portion not paid by insurance.

Signature: _____ Date: _____