Granite Bay Vision Care
Kevin Lockhart, O.D., Inc.

Kevin Lockhart, OD
Mahnoush Rafat, OD

Granite Bay Vision Care

5520 Douglas Blvd Ste 110, Granite Bay, CA 95746 916-791-5490

WELCOME TO OUR OFFICE! Please complete this form as accurately as possible

◯Male ◯Female ◯Mrs. ◯Mr. ◯Miss ◯Ms. ◯Dr.

Last Name:_____ First Name: _____

Middle Initial:_____ Nickname: _____ Birthdate: _____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone_____Cell Phone_____ Text OK?☐Yes☐No

Email: _____ _____ Preferred Method of Contact:☐Email☐Postal☐Phone

Employer(Or School):_____ Occupation(Or Grade)_____

Marital Status:_____ Name of Spouse: _____

Name of Responsible Person of Account:_____ Relationship:_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Referred By:_____

INSURANCE INFORMATION (Write " None" if no insurance)

	Company	Subscriber	Membership #
Primary Vision Insurance	_____	_____	_____
Secondary Vision Insurance	_____	_____	_____
Primary Medical Insurance	_____	_____	_____

Patient EYE History

Reason for Visit: ◯ Check Up (No Difficulty, Seeing Clearly and Comfortably)
◯ Seeing or Eye Problem (Please Explain)_____

How long ago was your last eye exam? _____ Dilated ◯Yes ◯No
Who was your last eye doctor?_____ Who is your primary care physician? _____
Do you wear glasses? ◯Yes ◯No How old are your present glasses?_____
Are you in interested in glasses for: ◯Distance ◯Near ◯Computer ◯Sports ◯Sunglasses
Have you had problems with prior glasses:_____

Have you ever worn contacts? ◯Yes ◯No Do you currently wear contact lenses? ◯Yes ◯No
State contact lens type (Brand, Base curve, Diameter & Power) _____
Rate how your contact lenses feel immediately after **first put** in
Poor ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ Excellent
Rate how your contact lenses feel just **before you take them out.**
Poor ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ Excellent
If not, are you interested in wearing contact lenses? ◯Yes ◯No ◯Maybe

Have You Ever Had Any Eye Disease, Eye Injury, Or Eye Surgery? ◯Yes ◯No (If Yes, please describe)
_____

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Patient Health History

Do you or anyone in your **immediate** family have any history of the following? If yes, please check the box.

Glaucoma	□Self □Family	Heart Disease	□Self □Family	Thyroid	□Self □Family
Cataract	□Self □Family	High Cholesterol	□Self □ Family	Arthritis	□Self □Family
Macular Degeneration	□Self □Family	Respiratory	□Self □ Family	Headache	□Self □Family
Retinal Detachment	□Self □Family	Neurological	□Self □ Family	Lupus	□Self □Family
Red Eyes	□ Self □Family	Gastrointestinal	□Self □ Family	Kidney	□Self □Family
Dry Eyes	□Self □Family	Cancer	□Self □ Family	Diabetes	□Self □Family
Watery Eyes	□Self □Family	Allergy	□Self □ Family		
Eye Injuries	□Self □Family	Itchy Eyes	□Self □Family	Pregnant/Nursing	□Yes □ No
High Blood Pressure	□Self □Family				

Are you currently taking any Drugs or Medications?
◯ Yes ◯No (If yes, please list)_____

_____

Are you **allergic** to any Drugs or Medications?
◯ Yes ◯No (If yes, please list)_____

_____

Do you currently smoke? ◯ Yes ◯No Have you ever Smoked before? ◯Yes ◯No Height:_____
Do you drink Alcohol? ◯ Yes ◯No Do you use recreational Drugs? ◯ Yes ◯No Weight:_____

I authorize the release of any medical information necessary to process any claims(s) to my insurance company, social security administration, or any of the above named insurances. I request all payments under the insurance program be made to me or to the provider for services and materials furnished to me during the effective period of this authorization. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges incurred and in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

I ACKNOWLEDGE THAT I RECEIVED A COPY OF GRANITE BAY VISION CARE'S NOTICE OF PRIVACY PRACTICES.

_____	_____	_____
Print Name (Patient or parent/guardian)	Print Signature (Patient or parent/guardian)	Date