GoTran Optometry
www.gotranoptometry.com
gotranoptometry@gmail.com

15061 Springdale St #103
Huntington Beach, CA 92649
Phone #: 714-898-3464

PERSONAL INFORMATION

Full Name:_____

Address:_____

City: _____ State: _____ Zip Code: _____

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

DOB: _____ /_____ /_____ Last 4 SSN #: _____ CA Driver's License #_____

Email: _____

Occupation: _____ Employer: _____

Family Doctor / PCP: _____ City: _____

Race/Ethnicity: _____

INSURANCE INFORMATION

Primary Insured Name: _____ Primary DOB: _____

Medical Insurance Carrier: _____ ID# _____

Vision Insurance Carrier: _____ ID# _____

Please provide ID cards for scanning.

By providing this information, I authorize Gotran Optometry INC to use this authorization in place of my physical signature on submissions to my insurance carrier. I authorize assignment of payments directly to Gotran Optometry INC when applicable. I understand that it is my responsibility to know the details of my individual insurance plan deductibles and co-pay/co-insurance amounts. I understand that although a procedure may be covered by my insurance, I may have amounts out-of-pocket for co-pays and co-insurance or if I have not yet met my deductible. I understand I am ultimately responsible for my/my child's charges if unpaid or denied by insurance as my insurance is a contract between myself and my insurance company and not Gotran Optometry INC or the provider.

I understand that the billing of insurance is determined by the reason for my visit as well as final diagnosis. I understand that vision insurance (ie. Eyemed, VSP, Davis Vision, Spectera, etc.) covers only routine/preventative eye examinations for purposes of vision correction and/or eye health screening. I understand that examinations for concerns such as diabetes, cataracts, glaucoma, eye pain, redness, "spots in vision", dry eye, blurry vision not due to the need for glasses/contacts, among other problem focused complaints are not addressed during a routine/preventative examination and any visit for those complaints will be considered a medical visit and will be billed through my medical insurance provider. I understand that, outside of urgent eye issues, I can request that my vision plan be used and may then return at a later date and time to address specific medical eye concerns with scheduled time for further testing and consultation with that visit billed to my medical plan.

PATIENT MEDICAL HISTORY FORM

1. What is the main reason for your visit today? _____

2. Do you wear glasses? _____ Do you wear contact lenses? _____

3. Allergies to Medications? _____

_____

4. Ocular History: Current Problems? Eye Surgeries? Eye Trauma? _____

_____

5. Medical History: Current conditions? _____

_____

6. Medication History: Current medication taken? _____

_____

7. Are you a diabetic? If so, list medication, last blood sugar level and time taken, last A1C level: _____

_____

8. Family Medical History: List any relevant family medical conditions and relation to patient: _____

_____

9. Special Conditions: Are you pregnant? _____ Possibly pregnant? _____ Breastfeeding? _____

10. Are you a current smoker? _____ Former smoker? _____ Never smoked? _____

11. Hobbies/Interests: _____

12. Daily Screen Time: _____ Do you experience eyestrain with computer use? _____

13. Do you have trouble driving at night? _____

14. Are you interested in laser (refractive) surgery to correct your vision? _____

15. How did you hear about our office? _____