EYEXAM
OF CALIFORNIA SM
A LICENSED VISION HEALTH CARE SERVICE PLAN

APPLICATION/MEMBER INFORMATION - Please Complete at Each Annual Examination (Please Print)

Last Name	First Name	Initial	Sex ☐ M ☐ F	Birthdate	Age

Home Address _____ City _____ State _____ Zip _____

Preferred Telephone Number ( ) ____________ Home Work Cell (circle option)
Secondary Telephone Number ( ) ____________ Home Work Cell (circle option)

We use phone calls to remind patients of their appointments. We will use the phone number you provide and the call may be live or prerecorded.

Language Preference: English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other ____________
Do you need assistance from an interpreter? ☐ Yes ☐ No

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other ____________

Employer Name	Employer Address	City	State

Your Occupation	Email Address

Will you be using any vision benefits or programs? ☐ No ☐ Yes If yes, please fill in the information below.

Vision Plan Name	Member ID #	Insured's Name	Patient's Relationship to Insured

Would you like to be billed for your services today through the *LENSCRAFTERS* account? ☐ Yes ☐ No
* **Note to Technician:** *If yes, please fill out LENSCRAFTERS account application.*

We will file an insurance claim for any plan under which we are providers. If you have a question about which plans for which we are providers, please ask the receptionist. Payment is expected at time of treatment.

Are you interested in looking at eyeglasses at LensCrafters today? ____________

HEALTH INFORMATION

1. Do you have? (please check all that apply)
   - ☐ eyestrain
   - ☐ dry eyes
   - ☐ floaters
   - ☐ frequent neck and shoulder pain
   - ☐ pain
   - ☐ itchy eyes
   - ☐ flashes of light
   - ☐ double vision
   - ☐ blurred vision with glasses or contacts
   - ☐ severe or frequent headaches
2. Name of your primary physician: ____________ Date of last physical: ______ HMO Member? ☐ No ☐ Yes
3. Age of present glasses: ____________ Date of last eye exam: ____________
4. Have you been examined at EYEXAM of California before? ☐ No ☐ Yes Which Office: ____________
5. Have your eyes been dilated before? ☐ No ☐ Yes When: ____________
6. Have you had retinal images taken before? ☐ No ☐ Yes When: ____________
7. Do you or any blood relatives (grandparents, parents, brothers, sisters, children) have? (please check all that apply)

	Self	Blood Relative		Self	Blood Relative		Self	Blood Relative
retinal disease/other	☐	☐	diabetes	☐	☐	asthma	☐	☐
ARMD	☐	☐	high cholesterol	☐	☐	lung disease	☐	☐
cataracts	☐	☐	high blood pressure	☐	☐	heart disease	☐	☐
glaucoma	☐	☐	thyroid problems	☐	☐			

8. Are you pregnant? (if applicable) ☐ No ☐ Yes Are you nursing? ☐ No ☐ Yes
9. Do you smoke? ☐ No ☐ Yes Do you drink alcohol? ☐ No ☐ Yes
10. Are you being treated for any medical condition? ☐ No ☐ Yes Please List ____________
11. Are you taking any medications? ☐ No ☐ Yes Please List ____________
12. Are you allergic to any medication including eye drops? ☐ No ☐ Yes Please List ____________
13. Do you have or have you ever had any eye disease, injury or surgery? ☐ No ☐ Yes

    If yes please explain: ____________

VERIFICATION

The information that I have provided above is accurate and complete to the best of my knowledge. I acknowledge that I have received a copy of the EYEXAM of California Combined Individual Membership Contract, Disclosure Form, and Evidence of Coverage.	Signature (If under 18 years of age, parent signature required)	Date