Christopher M. Wright, O.D.
534 S. Eighth Street
El Centro, CA 92243
(760) 352-4361

Personal Information * = Required Field

First Name*:
Middle Name / Initial:
Last Name*:
Suffix:
Gender*: Male: Female:
Date of Birth*:
Social Security No*:
Driver License:
Marital Status:
Emergency Contact*:
Relationship*:
Phone*:

Contact Information

Email*:

(We will NOT share your email with any third party. We will only use your email to contact you in relation to your care with our practice.)

Home Phone*:
Cell Phone*:
Work Phone:
Address*:
Address:
City*:
State*:
Zip Code*:

Insurance Information

Insurance Co. Name*:
Insurance Member*:
Ins. Member DOB*:
Ins. Member SSN*:
Relationship to Pt.*:

How did you hear about our office?

Referring Physician:
Referring Patient:
Referred By:
Other:

Employment Information

Work Status*: Fulltime: Parttime: Retired: Student:
Not Employed: Home: Disabled:
Employer Name:
Employer Address:
Employer Address:
Employer City:
Employer State:
Employer Zip Code:
Occupation:

Personal Health History

Medical Doctor:
Last Medical Exam Date:
Last Eye Exam Date:

Please Indicate If Any Of The Following Conditions Apply To YOU:

Pregnant Or Nursing:

Wear Glasses:

How Old Are Your Lenses?:

Wear Contacts:

How Old Are Your Lenses?:

Have Had Any Eye Infections:

Have Had Any Eye Injuries:

Have Had Any Eye Surgeries:

You Drive:

Vision Problems While Driving:

Are You Allergic to any Medication? Yes: No:

If Yes, Please List:

List Current Medications:

Family Health History

Please Indicate If YOU or Any FAMILY MEMBER Have Had Any Of The Following Conditions:

Blindness:		Diabetes:	
Cataract:		Heart Disease:	
Crossed Eyes:		High Blood Pressure:	
Glaucoma:		Kidney Disease:	
Macular Degeneration:		Lupus:	
Retinal Detachment:		Thyroid Disease:	
Arthritis:		Cholesterol:	
Cancer:		Other:	

Social History and Life Choices

Alcoholic Drinks:	Daily		Weekly		Occasionaly		Never
Caffinated Drinks:	Daily		Weekly		Occasionaly		Never
Tobacco Products:	Daily		Weekly		Occasionaly		Never
Controlled Drugs:	Daily		Weekly		Ocassionaly		Never

Please List any Hobbies, Sports or Activities That Are Of Interest To You:

Are You Exposed To?: Fumes Dust Chemiclas

How Many Hours A Day Do You Use Computers, Tablets Or Smart Phones?:

Have You Foreign Traveled Within The Last Year? Yes: No:

If Yes, Where To?:

Have You Ever Been Exposed To Or Infected With:

Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ Tuberculosis ☐

Health Problems And Concerns (Please Check All That Apply To YOU)

Systematic Review

- ☐ Fevers
- ☐ Weight Change
- ☐ Skin Problems
- ☐ Headaches
- ☐ Migrains
- ☐ Fainting
- ☐ Seizures

Eyes And Vision

- ☐ Flashes
- ☐ Floaters
- ☐ Halos
- ☐ Tired Eyes
- ☐ Vision Loss
- ☐ Side Vision Loss
- ☐ Blurred Vision
- ☐ Distorted
- ☐ Double Vision
- ☐ Dryness
- ☐ Sandy Feeling
- ☐ Eye Itch
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Burning
- ☐ Foreign Body Sensation
- ☐ Tearing
- ☐ Watery
- ☐ Light Sensitive
- ☐ Soreness
- ☐ Pain
- ☐ Infection
- ☐ Stie Or Chalazion

Ears, Nose, Mouth, Throat

- ☐ Allergies
- ☐ Hay Fever
- ☐ Coughing
- ☐ Dryness
- ☐ Sinus congestion
- ☐ Runny Nose
- ☐ Post-Nasal Drip

Lungs

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Enphysema
- ☐ Shortness of Breath

Cardiovascular

- ☐ Heart Pain
- ☐ High Blood Pressure
- ☐ Vascular Disease
- ☐ Strokes
- ☐ Cholesterol

Gastro-Intestinal System

- ☐ Diarrhea
- ☐ Constipation

Muscles And Joints

- ☐ Arthritis
- ☐ Muscle Cramps
- ☐ Muscle Soreness
- ☐ Joint Soreness

Endocrinologic

- ☐ Thyroid
- ☐ Other Glands
- ☐ Diabetes
- ☐ Anemia
- ☐ Bleeding Problems

Financial Responsibility / Release of Records / Privacy Notice

Payment for services is due at the time of service. Payment is also required before any materials will be ordered. All insurance co-payments and materials charges (glasses or contact lenses) that exceed your insurance coverage and discounts must be paid in full before any materials will be released.

When using vision or health insurance, please check your own benefits manual to review coverage. There are many insurance carriers and we will do all that we can to help you receive your maximum coverage.

I understand that I am financially responsible for all the charges whether my insurance pays or not.

I hereby give authorization for payments of insurance benefits to be made to Christopher M. Wright O.D., for services rendered.

I hereby authorize the release of my records to any hospital, medical practitioner or insurance company that requires this information.

I have read the above conditions and agree to their content:

Signature of Patient, Parent or Guardian Date

I have **Received** / **Refused** (please circle one) a copy of Dr. Wright's **Joint Notice Of Privacy Practices**.

Signature	Date