PATIENT FORM

VANG FAMILY OPTOMETRY

GENERAL INFORMATION

First, MI, Last:

Street Address:

City, State, Zip:

Social Security Number: Date of Birth: *Male | Female*

Phone: *home | cell | work* Email:

Preferred Contact Method: *phone | email | text | other (please explain):*

Primary Care Doctor:

Emergency Contact Person: Phone: Relation:

How did you hear about us? *Insurance website | Google | Yelp | Walk by | Referral: whom may we thank?*

INSURANCE INFORMATION (skip if self-pay)

Please present ALL vision and medical insurance cards to receptionist to reduce your out-of-pocket costs and to assist us in referrals.

Vision Insurance: Primary Member Name:

Primary Member Date of Birth: Primary Member Social Security Number:

Primary Medical Insurance: Primary Member Name:

Insurance ID#: Primary Member Employer:

Your Relationship to Primary Member: *spouse | child | other (please explain):*

Other Insurance?

I hereby authorize Vang Family Optometry to apply for benefits on my behalf for covered services rendered. I also assign my benefits and request that all payments from my insurance(s) are made directly to Vang Family Optometry. I agree to assume responsibility for full payment pending any remaining balance that is not covered by my insurance(s).

I certify that the information I have reported with regard to my coverage is correct. I further authorize Vang Family Optometry to release to my insurance carrier(s) and its agents any information needed to determine payments for related services.

Signature	Relationship to Patient (if not self)	Date

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.
(M: Mother, F: Father, B: Brother, S: Sister, GP: Grandparent)

Cataracts	*no*	*self*	*M | F | B | S | GP*
Crossed Eye	*no*	*self*	*M | F | B | S | GP*
Glaucoma	*no*	*self*	*M | F | B | S | GP*
LASIK or RK	*no*	*self*	*M | F | B | S | GP*
Lazy Eye	*no*	*self*	*M | F | B | S | GP*
Macular Degeneration	*no*	*self*	*M | F | B | S | GP*
Retinal Detachment	*no*	*self*	*M | F | B | S | GP*

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Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*no*	*self*	*M | F | B | S | GP*
Allergies	*no*	*self*	*M | F | B | S | GP*
Arthritis	*no*	*self*	*M | F | B | S | GP*
Asthma	*no*	*self*	*M | F | B | S | GP*
Blood/Lymph Disorder	*no*	*self*	*M | F | B | S | GP*
Cancer	*no*	*self*	*M | F | B | S | GP*
Diabetes	*no*	*self*	*M | F | B | S | GP*
Ears, Nose, Throat Conditions	*no*	*self*	*M | F | B | S | GP*
Gastrointestinal Conditions	*no*	*self*	*M | F | B | S | GP*
Heart Disease	*no*	*self*	*M | F | B | S | GP*
High Blood Pressure	*no*	*self*	*M | F | B | S | GP*
High Cholesterol	*no*	*self*	*M | F | B | S | GP*
Kidney Disease	*no*	*self*	*M | F | B | S | GP*
Lupus	*no*	*self*	*M | F | B | S | GP*
Neurological Conditions	*no*	*self*	*M | F | B | S | GP*
Psychiatric Disorder	*no*	*self*	*M | F | B | S | GP*
Seizures	*no*	*self*	*M | F | B | S | GP*
Skin Conditions	*no*	*self*	*M | F | B | S | GP*
Stroke	*no*	*self*	*M | F | B | S | GP*
Thyroid Dysfunction	*no*	*self*	*M | F | B | S | GP*

If you answered yes to any conditions, please explain (if needed):

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Females: Are you pregnant or nursing? *yes | no*

Do you smoke? *yes | no*

How much?

Have you ever smoked? *yes | no*

Do you drink alcohol? *yes | no*

How much?