Dr. Hong T. Nguyen
Optometric Physician

WELCOME

Thank you for choosing our office for your eye care needs. Please fill out on both sides as completely as you can. Thank You!

PATIENT INFORMATION

Today's Date_____

First Name_____ Middle Initial_____ Last Name_____ SS#_____

Address_____ City_____ State_____ Zip_____

Sex: □ M □ F Age_____ Birth Date_____ □ Single □ Married □ Widowed

Home Phone_____ Work Phone_____ Occupation_____

Employer_____

Parent Name (If minor)_____ Spouse Name_____

Does Today's Visit Involve Testing and Evaluation For Contact Lenses? □ Yes* □ No

** If yes, please initial here if you understand that there will be an additional charge*_____

INSURANCE INFORMATION

How will you pay for today's visit? **□ Cash / Check** **□ Mastercard / Visa** **□ Insurance Coverage**

Name of Person Responsible for this Account_____ Responsible Party SS#_____

Relationship_____ Employer_____

Are You Covered by Vision Insurance? □ Yes □ No Are You Covered by Major Medical Insurance? □ Yes □ No

Name of Insurance_____ Name of Insurance_____

Subscriber_____ Subscriber_____

Group #_____ Group #_____

Member #_____ Member #_____

Release of benefits of Medical Information: I hereby authorize my insurance benefits be paid directly to the physician. I understand that a statement of benefits from my insurance company is not a guarantee of payment and I am financially responsible for any balance due. I also authorize the physician to release any information required to process this claim.

SIGNATURE_____ DATE_____

Must be the signature of the person who is financially responsible for the services rendered

EYE HEALTH HISTORY

Eye Physician's Name_____ Date of Last Eye Exam_____

Reason For Today's Visit?_____

Do you wear glasses? □ Yes □ No □ All the time □ Occasionally □ Reading □ Driving □ TV

Do you wear contacts? □ Yes □ No Brand/Type_____ Hours/Days_____

Describe any problems you have with your contacts_____

Please mark the box if you are currently experiencing any of the following

Blurred Vision—*Distance*	□	Blurred Vision—*Near*	□	Seeing Halos	□	Poor Color Vision	□
Crossed Eyes	□	Double Vision	□	Poor Night Vision	□	Temporary Loss of Vision	□
Dry Eyes	□	Watering Eyes	□	Burning Eyes	□	Twitching Eyelid	□
Eye Infection	□	Discharge from Eyes	□	Itching Eyes	□	Red Eyes	□
Seeing Flashes	□	Floaters or Spots	□	Light Sensitivity	□	Eye Pain	□
Headaches	□	*Other*		*List*_____			

Please Continue On Other Side →

PERSONAL HEALTH HISTORY

Family Physician's Name_____ Date of last visit_____

Please place a mark to indicate if you currently have or have had any of the following conditions

	Yes	No		Yes	No
Eye Injury	☐	☐	Diabetes	☐	☐
Eye Surgery	☐	☐	High Blood Pressure	☐	☐
Glaucoma	☐	☐	Heart Condition	☐	☐
Macular Degeneration	☐	☐	Breathing / Lungs	☐	☐
Retinal Disease	☐	☐	Parkinson	☐	☐
Corneal Disease	☐	☐	Migraine Headaches	☐	☐
			Arthritis	☐	☐
AIDS/HIV	☐	☐	Multiple Sclerosis	☐	☐
Cancer (Type_____)	☐	☐	Thyroid Condition	☐	☐
Stroke	☐	☐	Digestive, abdominal	☐	☐
Shingles	☐	☐	Urinary, kidney	☐	☐
Allergies / Hay Fever	☐	☐	Other_____		

Do You smoke? Y___N___ Use Alcohol? Y___N___ Use recreational drugs? Y___N___

If Female, are you pregnant or breast feeding? Y___N___

FAMILY HEALTH HISTORY

Please place a mark to indicate if a blood relative currently have or have had any of the following conditions

	Yes	No		Yes	No
Glaucoma	☐	☐	Diabetes	☐	☐
Blindness	☐	☐	High Blood Pressure	☐	☐
Macular Degeneration	☐	☐	Heart Condition	☐	☐
Retinal Disease	☐	☐	Arthritis	☐	☐
Corneal Transplant	☐	☐	Thyroid Condition	☐	☐
Cancer (Type_____)	☐	☐	Systemic Lupus	☐	☐

MEDICATIONS	ALLERGIES
List Medications you are currently taking including eye drops	List your allergies to medications or other substances
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Pharmacy Name_____	
Phone _____	

Who referred you to our office, or where did you learn of us?_____

THANK YOU FOR FILLING OUT THIS FORM