PATIENT INFORMATION FORM

Last Name	First Name	MI	Sex	Birthdate	Age

Home Address	City	State	Zip	Home Phone #
Work Name / Address	**City**	**State**	**Zip**	**Work Phone #**
				Cell Phone #
Social Security Number	**Occupation**	**Referred By:**		
				E-mail Address

Method of Payment: [ ] Cash / Check / Charge [ ] VSP [ ] Medi-Cal [ ] Medicare [ ] Medical Eye Services [ ] Other

Language: [ ] English [ ] Cantonese [ ] Mandarin [ ] Spanish [ ] Other

Insurance or Person Responsible for Account

Subscriber Name	Social Security #	Insurance ID #	Group #	Relationship to Patient
Insurance Co.	**Insurance Address**			**Insurance Phone#**

Patient History

1. **Primary reason for today's exam:** [ ] Glasses requested [ ] CL requested [ ] Laser Surgery Consultation [ ] Blur far [ ] Blur near [ ] Pain / Discomfort [ ] Other
2. **Age of present glasses:** _____ **Last eye examination date:** _____ **From Dr:** _____
3. **Condition of glasses:** [ ] Broken [ ] Scratched [ ] Lost [ ] Satisfactory
4. **Do you or any blood relatives have diabetes?** [ ] Yes [ ] No **Who?** _____
   High blood pressure? [ ] Yes [ ] No **Who?** _____
   Heart disease? [ ] Yes [ ] No **Who?** _____
   Thyroid problems? [ ] Yes [ ] No **Who?** _____
   Other health problems? **Please List:** _____
   Cataracts? [ ] Yes [ ] No **Who?** _____
   Glaucoma? [ ] Yes [ ] No **Who?** _____
   Blindness? [ ] Yes [ ] No **Who?** _____
   Retinal detachment or degeneration? [ ] Yes [ ] No **Who?** _____
   Other eye conditions? **Please List:** _____
5. **Are you pregnant or breast feeding?** [ ] Yes [ ] No **What?** _____
6. **Do you have any allergies?** [ ] Yes [ ] No **What?** _____
7. **Are you taking any medications?** [ ] Yes [ ] No **What?** _____
8. **Do you use cigarettes, alcohol, or other substance?** [ ] Yes [ ] No **What?** _____
9. **Have you ever had any eye disease, injury or surgery?** [ ] Yes [ ] No **When?** _____
10. **Do you have unusually frequent or severe headaches?** [ ] Yes [ ] No **When?** _____
11. **Do you work with a computer?** [ ] Yes [ ] No **Hrs / Day?** _____
12. **What sports and hobbies do you enjoy participating?** **Please List:** _____
13. **Are you interested in new contact lenses?** [ ] Yes [ ] No **What type?** _____

Authorization Statement

Please be advised that you are financially responsible for all the fees and charges regardless of insurance coverage. However, at your requests, we will bill your insurance if you provide complete, accurate insurance information along with a signed insurance claim form and/or a copy of your insurance card.

I hereby authorize Dr. Mindy Young to furnish information to insurance carriers concerning my conditions and treatments. I also assign to the doctor all payments for optometric services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Patient's Signature _____ **Date:** _____
(Parent / Guardian, if patient is under 18)