WELCOME

11893 Valley View St.
Garden Grove, CA 92845

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to meeting your eye care needs with professional vision care.

PATIENT INFORMATION

Date _____

Last Name _____

First Name _____ **Middle Initial** _____

Title _____ **Suffix** _____ **Nickname** _____

Sex ☐ M ☐ F

Birthdate _____ **SSN#** _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____

Daytime Phone _____

Cell Phone _____ **Text? Y N**

Email Address _____

Who may we thank for referring you? _____

Do you have a Flexible Spending Account? Y N

Please circle the purpose(s) of this visit:

Eye Exam | Contact Lens Exam | LASIK | Red Eye/Medical

Sunglasses | Safety Glasses | Corneal Reshaping Therapy

EMPLOYMENT INFORMATION

Occupation _____

Employer _____

Phone _____

EMERGENCY CONTACT INFORMATION

Name _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____

Daytime Phone _____

INSURANCE INFORMATION

Primary Vision Insurance Name _____

Primary member for this plan _____

ID of Primary Member _____

Birthdate (of primary) _____

SSN# (of primary) _____

Relationship to patient _____

Secondary Vision Insurance Name _____

Primary member for this plan _____

ID of Primary Member _____

Birthdate (of primary) _____

SSN# (of primary) _____

Relationship to patient _____

Medical Insurance Name _____

Primary member for this plan _____

ID of Primary Member _____

Birthdate (of primary) _____

SSN# (of primary) _____

Relationship to patient _____

Name of Primary Care Provider _____

Phone Number (of PCP) _____

AUTHORIZATION AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Hollie Huynh, OD, all
Name of Primary Insurance
insurance benefits, if any otherwise payable to me for services rendered. I accept responsibility for payment of any portion of vision services rendered which are not covered by my insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient or Parent/Guardian

_____
Printed Name of Patient or Parent/Guardian

_____ _____
Date *Relationship to Patient*

HIPAA Agreement *(Health Insurance Portability and Accountability Act)*

In the course of providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices describes these uses and disclosures in detail. By signing this form, I acknowledge that I have received the Notice of Privacy Practices from Eastgate Optometry.

_____ _____
Signature *Date*

EYEWEAR HISTORY

Date of last eye exam _____

Do you wear glasses? Y N ☐ **All the time** ☐ **Computer** ☐ **TV** ☐ **Reading** ☐ **Driving**

Do you wear contacts? Y N **Type** _____ **Hours/day** _____ **Lens Solution** _____

Do you have any issues with your glasses or contacts? _____

MEDICAL HISTORY

Please mark any of the following medical conditions that you currently have or have had:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Cancer:
  Type _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes:
  Type _____
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis:
  Type _____
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

Have you had any surgeries? Y N
Type _____ Date _____

MEDICATIONS

Please specify any medications you are currently taking:

_____

_____

_____

_____

_____

ALLERGIES

Please specify any allergies and resulting reactions you have:

_____

_____

_____

_____

_____

OCULAR HISTORY

Please mark any of the following ocular conditions that you currently have or have had:

- ☐ Allergic Conjunctivitis
- ☐ Eyelid Inflammation
- ☐ Cataract:
  Which eye? R L
- ☐ Corneal Dystrophy:
  Which eye? R L
- ☐ Diabetic Retinopathy:
  Stage: Early Late
  Which eye? R L
- ☐ Dry Eyes
- ☐ Glaucoma:
  Which eye? R L
- ☐ Macular Degeneration:
  Which eye? R L
- ☐ Blurred Distance Vision
- ☐ Blurred Near Vision
- ☐ Blurred Computer Vision
- ☐ Burning Eyes
- ☐ Discharge from Eyes
- ☐ Dizziness/Headaches
- ☐ Double Vision
- ☐ Eye Infection
  Start Date: _____
- ☐ Itching Eyes
- ☐ Lazy Eye
- ☐ Light Sensitivity
- ☐ Poor Color Vision
- ☐ Poor Night Vision
- ☐ Macular ERM:
  Which eye? R L
- ☐ Ocular Hypertension:
  Which eye? R L
- ☐ Ophthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal Tear:
  Which eye? R L
- ☐ Crossed Eyes
- ☐ PVD
- ☐ Floaters
  Which eye? R L
- ☐ Other _____
  _____
- ☐ Red Bloodshot Eyes
- ☐ Seeing Halos/Glares
- ☐ Twitching Eyelid
- ☐ Watering Eyes

Have you had any eye injuries? Y N
If yes, what type and when?
_____
_____

Have you had any eye surgeries? Y N
If yes, what type and when?
_____
_____

SOCIAL HISTORY

Please mark anything that describes your current smoking status:

- ☐ Daily
- ☐ Some Days
- ☐ Former Smoker
- ☐ Non-Smoker
- ☐ Cigars
- ☐ Cigarettes
- ☐ Heavy Tobacco
- ☐ Light Tobacco

Please mark anything that describes your current alcohol usage:

- ☐ None
- ☐ <1 drink/day
- ☐ 1-2 drinks/day
- ☐ 3+ drinks/day
- ☐ Social drinking only

Please mark anything that describes your current exercise status:

- ☐ Several times/day
- ☐ Once a day
- ☐ Few times/week
- ☐ Few times/month
- ☐ Never
- ☐ Other _____

Please mark anything that describes your current caffeine usage:

- ☐ Several times/day
- ☐ Once a day
- ☐ Few times/week
- ☐ Few times/month
- ☐ Never
- ☐ Rarely

FAMILY HISTORY

Please mark any of the following conditions that a family member currently has or had and specify the relation:

- ☐ Cancer
  Type: _____
  Relation _____
- ☐ Cataracts
  Relation _____
- ☐ Diabetes
  Type: _____
  Relation _____
- ☐ Glaucoma
  Relation _____
- ☐ Heart Condition
  Type: _____
  Relation _____
- ☐ High Blood Pressure
  Relation _____
- ☐ High Myopia / High Rx
  Relation _____
- ☐ Macular Degeneration
  Relation _____
- ☐ Retinal Detachment
  Relation _____