Welcome to EYQE optometry

Dr. Christyn Mai Phan
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PATIENT INFORMATION (PLEASE PRINT)

LAST NAME	FIRST NAME	M.I	SEX	BIRTH DATE	AGE

ADDRESS	CITY	STATE	ZIPCODE

HOME PHONE	CELL PHONE	OCUPATION	REFERRED BY:

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. I ALSO AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN, AND I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES.

SIGNATURE________________________________DATE__________________
(If patient is under 18 years, parent signature required)

SOCIAL SECURITY#________________________________

INSURANCE:
- ☐ V.S.P
- ☐ M.E.S
- ☐ EYEMED
- ☐ SPECTERA
- ☐ MEDICARE
- ☐ MEDICAL
- ☐ BLUE CROSS/ BLUE SHIELD
- ☐ COLE VISION
- ☐ HEALTHY FAMILY
- ☐ CAL OPTIMA
- ☐ OTHERS ____________________
- ☐ PRIVATE PAY

WHAT IS THE REASON FOR YOUR VISIT TODAY?
- ☐ Routine Yearly Eye Health Exam
- ☐ Problem Related Exam for Eye Conditions/Diseases
- ☐ Eye Exam for Eye Glasses
- ☐ Eye Exam for Contact Lenses
- ☐ Laser Surgery Consultation
- ☐ Others ____

FOR RETURNING PATIENTS: If you have visited our office before and there is no change in your medical history, please acknowledge by signing below and skip the rest. Otherwise, please complete section "For New Patients" below if there are new changes or if you are a new patient to this clinic.

________________________________ ________________________________
Signature (If patient is under 18 years, parent signature required) Date

FOR NEW PATIENTS: Please complete the following patient's medical and eye history.

Last Eye exam Date__________ From Dr.__________ Last Medical Exam__________ Plan name or Dr.__________

- Have you ever worn eye glasses or contact lenses before? ☐ Yes ☐ No If yes, Age of Present Glasses or Contacts________
- Do you wear contact lenses now? ☐ Yes ☐ No If yes, which type________________
- Do you see well with your current glasses or contacts? ☐ Yes ☐ No
- Have you ever had pink eye or any type of eye infection? ☐ Yes ☐ No If yes, what and when________________
- Have you ever had any eye trauma/injuries/ laser/surgery? ☐ Yes ☐ No If yes, what and when________________
- Do you have any other eye diseases or conditions? ☐ Yes ☐ No If yes, explain________________
- Have your eyes ever been dilated before? ☐ Yes ☐ No If yes, when________________
- Are you currently taking any medication? ☐ Yes ☐ No If yes, which kind________________
- Are you allergic to any medication? ☐ Yes ☐ No If yes, which kind________________

Please check any of the following that apply to you.

- ☐ Distance vision blurry or discomfort
- ☐ Eye strain/fatigue
- ☐ See floaters/spots
- ☐ Itching/burning/red eyes
- ☐ Near vision blurry or discomfort
- ☐ Bright light sensitivity
- ☐ See flashing lights
- ☐ Dry eyes
- ☐ Fluctuating/variable vision
- ☐ Headache related to eyes
- ☐ Double vision
- ☐ Watery eyes
- ☐ Trouble with night vision
- ☐ Computer vision problem
- ☐ Need computer/safety/occupational/sport eyewear

Do you or any of your family members suffer from any of the following conditions? Please check self or family.

Self	Family		Self	Family		Self	Family		Self	Family	
☐	☐	Glaucoma	☐	☐	Macular Degeneration	☐	☐	Lazy/Cross eyes	☐	☐	Retinal detachment
☐	☐	Cataracts	☐	☐	Blindness/other degenerations	☐	☐	Diabetes	☐	☐	High blood pressure
☐	☐	Heart diseases	☐	☐	Cholesterol problems	☐	☐	Cancer	☐	☐	Thyroid condition
☐	☐	Asthma/lung problems	☐	☐	Infectious /STD (e.g. TB, HIV)	☐	☐	Others________________			