VISION CARE
Dr. Gina T. Huynh, O.D.
Dr. Victor T. Chu, O.D.

Ms./ Miss/ Mrs./ Mr./ Dr./ PhD _____ Date of Birth: _____

Address: _____ Home Ph: _____

City/State/Zip: _____ Work Ph: _____

SSN: _____ Email: _____ Cell Ph: _____

Parent's Name (if minor): _____ ☐ Single ☐ Married ☐ Life Partner

Employer: _____ Occupation: _____ ☐ Full time ☐ Part time ☐ Full-time Student

Preferred Language: _____ Race: _____ Ethnicity: _____

Insurance co. #1: _____ ☐ Vision ☐ Medical Subscriber: _____ DOB: _____

Contact #: _____ ☐ HMO ☐ PPO ☐ Traditional Group #: _____

Insurance co. #2: _____ ☐ Vision ☐ Medical Subscriber: _____ DOB: _____

Contact #: _____ ☐ HMO ☐ PPO ☐ Traditional Group #: _____

Primary care physician: _____ Phone: _____

Address: _____

Hobbies, special vision needs: _____

I wear glasses: ☐ Yes ☐ No I have had laser corrective surgery: ☐ Yes ☐ No Interested in LASIK? ☐ Yes ☐ No

I wear contact lenses: ☐ Yes ☐ No Type: _____ I replace my contacts every: _____

When was your last eye exam: _____ Name of previous eye doctor: _____

Referred by: _____ ☐ Doctor ☐ Friend ☐ Family ☐ Insurance co. ☐ Advertisement

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Due to the Health Insurance Portability and Accountability Act your initials & signature are required below

Initials:

_____ I *authorize* any holder of my medical information about me to release to my insurance company or its agent any information needed to determine these benefits payable or related services. I request that payment of authorized services be made on my behalf to Vision Care. I agree to be personally and fully responsible for co-pays, deductibles, non-covered and denied services by my insurance company.

OR

_____ I *decline* the above information release and am solely responsible for fees. I understand that fees are due at time of service.

_____ I authorize any holder of medical information about me to release and/or request my medical information with other health care professionals for the purpose of consultation and referral as appropriate for my health care.

_____ I have been provided the Vision Care Privacy Policy. [You may request a copy for your records]

Signature _____ Relationship to patient _____ Date _____

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Patient Name: _____ **Date:** _____

General Health Information Sheet

Please list any medications:

_____
_____
_____
_____
_____

Please list any allergies (medical & general):

_____
_____
_____

Do any of the following conditions apply to you?:

__ Constitutional (fever, weight change)
__ Stomach or Gastrointestinal
__ Asthma
__ Heart condition/disease
__ Psychological
__ Multiple Sclerosis
__ Cancer
__ Ear/Nose/Mouth/Throat
__ Kidney or Liver
__ Diabetes
__ High Blood Pressure
__ Blood disorder
__ Arthritis or joint
__ Immune Deficiency
__ Skin condition
__ Lung or Respiratory
__ Stroke
__ High Cholesterol
__ Thyroid
__ Pregnant
__ Headaches
__ Lazy eye or eye turn
__ Macular Degeneration
__ Retinal Detachment
__ Cataracts
__ Glaucoma
__ Dry Eye

__ Tobacco: ☐ Light ☐ Moderate ☐ Heavy
__ Alcohol: ☐ Light ☐ Moderate ☐ Heavy
__ Drug Use: ☐ Light ☐ Moderate ☐ Heavy

Height: _____ **Weight:** _____

If you indicated any of the above conditions apply to you, please explain and list treatment:

_____
_____
_____
_____

Please list any other health conditions:

_____
_____
_____

Does your family history include any of the following? If yes, what is the relationship to you?

Relationship:

__ Glaucoma _____
__ Cataracts _____
__ Macular Degeneration _____
__ Retinal Detachment _____
__ Blindness _____

Relationship:

__ High Blood Pressure _____
__ Diabetes _____
__ Heart _____
__ Thyroid Condition _____
__ Other _____

Signature _____ **Date** _____