



## Personal Information

M  F    /    /    \_\_\_\_\_  
**Gender**    **Date of Birth**    **Age**

\_\_\_\_\_  
**First Name**    **M.I.**    **Last Name**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City**    **State**    **Zip**

\_\_\_\_\_  
**Occupation**

**Vision Insurance**  Yes  No    \_\_\_\_\_  
**Insurance Name/Type**    **SSN of Primary on Insurance**    **Auth. Code (filled in by office)**

**Contact Information**  
 Home Number \_\_\_\_\_  
 Work Number \_\_\_\_\_  
 Mobile Number \_\_\_\_\_  
 Email Address \_\_\_\_\_

## Referral Information

**Internet**  
 Website, Search Engines...

**Yellowpages**  
 Business listings

**Insurance**  
 Providers website, phone, etc.

**Signs**  
 Billboards, street signs...

**Print**  
 Postcards, Flyers, Newspapers...

**Word of Mouth**  
 Friends, family, other

**Walk-In**  
 No Prior Knowledge

**Other**  
 \_\_\_\_\_

## Visit Information

**Personal History**    **Type of Visit**  Spectacle Exam     Contact Lens Exam     Office Visit

**Date of Last Exam** \_\_\_\_\_

**Previous Doctor** \_\_\_\_\_

**Medications you're taking** \_\_\_\_\_

**Medications allergic to** \_\_\_\_\_

**Check any conditions that apply to you or an immediate family member**

	You	Family Member	You	Family Member
<b>Diabetes</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Glaucoma</b>	<input type="checkbox"/>
<b>Heart Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lazy Eye</b>	<input type="checkbox"/>
<b>Headaches</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Eye Surgery</b>	<input type="checkbox"/>
<b>High Blood Pressure</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other Important Information About Your Eyes</b>	

\_\_\_\_\_

Have you ever worn glasses  Yes  No  
 Have you ever worn contacts  Yes  No  
 Do you currently wear contacts  Yes  No

### If you currently wear contacts...

**Type of Contacts**  
 1 Day     2 Weeks     1 Month     1 Year    \_\_\_\_\_  
**Powers** Right Eye: \_\_\_\_\_ Left Eye: \_\_\_\_\_    **Brand Name** \_\_\_\_\_  
 How often do you dispose your contact lenses: \_\_\_\_\_  
 Do you sleep with your contacts on:  Yes  No    How often: \_\_\_\_\_

### Dilation Information

Dilation is the use of drops to temporarily enlarge the pupil. It allows the doctor to better look for things such as retinal holes, detachments, tumors, signs of high blood pressure, diabetes, and glaucoma that can be otherwise missed. Dilation takes an additional 20-30 minutes. **There is an additional charge of \$20.00 for this service.**  Yes  No

## Financial Statement

I hereby authorize Dr. Quang Pham to release or exchange any information necessary to process my insurance claim. I will receive services with the understanding that in the event my coverage is not effective, I will be billed by Dr. Quang Pham and will be held financially responsible for services rendered. Furthermore, I understand what my benefits are and that there may be additional charges over and above those covered by my benefits.

### Acknowledgement of Receiving Notice of Privacy Practices

I acknowledge that I received a copy of Quang Pham, O.D.'s Notice of Privacy Practices. In addition, I agree to the Financial Statement and certify that all the information provided is correct and current to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Payment Type:**  Cash     Check     Credit Card