



# 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 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:

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

Have you had any surgeries?    Y   N  
Type \_\_\_\_\_                      Date \_\_\_\_\_

## MEDICATIONS

Please specify any medications you are currently taking:

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## ALLERGIES

Please specify any allergies and resulting reactions you have:

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## OCULAR HISTORY

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

- |  |   |
|--|---|
| <input type="checkbox"/> Allergic Conjunctivitis | <input type="checkbox"/> Macular ERM:         |
| <input type="checkbox"/> Eyelid Inflammation     | Which eye?   R   L                            |
| <input type="checkbox"/> Cataract:               | <input type="checkbox"/> Ocular Hypertension: |
| Which eye?   R   L                               | Which eye?   R   L                            |
| <input type="checkbox"/> Corneal Dystrophy:      | <input type="checkbox"/> Ophthalmic Migraine  |
| Which eye?   R   L                               | <input type="checkbox"/> Pseudoexfoliation    |
| <input type="checkbox"/> Diabetic Retinopathy:   | <input type="checkbox"/> Retinal Tear:        |
| Stage:   Early   Late                            | Which eye?   R   L                            |
| Which eye?   R   L                               | <input type="checkbox"/> Crossed Eyes         |
| <input type="checkbox"/> Dry Eyes                | <input type="checkbox"/> PVD                  |
| <input type="checkbox"/> Glaucoma:               | <input type="checkbox"/> Floaters             |
| Which eye?   R   L                               | Which eye?   R   L                            |
| <input type="checkbox"/> Macular Degeneration:   | <input type="checkbox"/> Other _____          |
| Which eye?   R   L                               | _____   |

- |  |  |
|--|--|
| <input type="checkbox"/> Blurred Distance Vision | <input type="checkbox"/> Red Bloodshot Eyes  |
| <input type="checkbox"/> Blurred Near Vision     | <input type="checkbox"/> Seeing Halos/Glares |
| <input type="checkbox"/> Blurred Computer Vision | <input type="checkbox"/> Twitching Eyelid    |
| <input type="checkbox"/> Burning Eyes            | <input type="checkbox"/> Watering Eyes       |

**Have you had any eye injuries?**   Y   N

If yes, what type and when?

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**Have you had any eye surgeries?**   Y   N

If yes, what type and when?

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- |  |
|--|
| <input type="checkbox"/> Discharge from Eyes |
| <input type="checkbox"/> Dizziness/Headaches |
| <input type="checkbox"/> Double Vision       |
| <input type="checkbox"/> Eye Infection       |
| Start Date: _____                            |
| <input type="checkbox"/> Itching Eyes        |
| <input type="checkbox"/> Lazy Eye            |
| <input type="checkbox"/> Light Sensitivity   |
| <input type="checkbox"/> Poor Color Vision   |
| <input type="checkbox"/> Poor Night Vision   |

## SOCIAL HISTORY

Please mark anything that describes your current smoking status:

- |  |                                     |  |
|--|-------------------------------------|--|
| <input type="checkbox"/> Daily         | <input type="checkbox"/> Non-Smoker | <input type="checkbox"/> Heavy Tobacco |
| <input type="checkbox"/> Some Days     | <input type="checkbox"/> Cigars     | <input type="checkbox"/> Light Tobacco |
| <input type="checkbox"/> Former Smoker | <input type="checkbox"/> Cigarettes |  |

Please mark anything that describes your current alcohol usage:

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> None         | <input type="checkbox"/> 1-2 drinks/day | <input type="checkbox"/> Social drinking |
| <input type="checkbox"/> <1 drink/day | <input type="checkbox"/> 3+ drinks/day  | only                                     |

Please mark anything that describes your current exercise status:

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Several times/day | <input type="checkbox"/> Few times/week  | <input type="checkbox"/> Never       |
| <input type="checkbox"/> Once a day        | <input type="checkbox"/> Few times/month | <input type="checkbox"/> Other _____ |

Please mark anything that describes your current caffeine usage:

- |  |  |                                 |
|--|--|---------------------------------|
| <input type="checkbox"/> Several times/day | <input type="checkbox"/> Few times/week  | <input type="checkbox"/> Never  |
| <input type="checkbox"/> Once a day        | <input type="checkbox"/> Few times/month | <input type="checkbox"/> Rarely |

## FAMILY HISTORY

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

- |  |                |
|--|----------------|
| <input type="checkbox"/> Cancer                | Relation _____ |
| Type: _____                                    |                |
| <input type="checkbox"/> Cataracts             | Relation _____ |
| <input type="checkbox"/> Diabetes              | Relation _____ |
| Type: _____                                    |                |
| <input type="checkbox"/> Glaucoma              | Relation _____ |
| <input type="checkbox"/> Heart Condition       | Relation _____ |
| Type: _____                                    |                |
| <input type="checkbox"/> High Blood Pressure   | Relation _____ |
| <input type="checkbox"/> High Myopia / High Rx | Relation _____ |
| <input type="checkbox"/> Macular Degeneration  | Relation _____ |
| <input type="checkbox"/> Retinal Detachment    | Relation _____ |