INLAND FAMILY optometry

Patient Information Form

Patient Last Name	First name	Middle Initial		Male	Female
Address	City		State	Zip	
Home Phone	Mobile Phone		Birth Date / /		Age
Employer	Address		Patients SS# *Needed for Insurance purposes ONLY*		
Occupation	Marital Status: Single □ Married □ Other □				
Reason For Visit: EYE EXAM □ SPECIFIC PROBLEM:					
ARE YOU INTERESTED IN: CONTACT LENSES ☐ LASIK ☐ BLUE LIGHT LENSES ☐					

Parent/Person Responsible Information & Insurance Information

Primary Vision Insurance	Policy #			
Secondary Vision Insurance	Policy #			
Name	Relationship to Patient:	SS#		
Home Phone	Mobile Phone	Birth Date		Age
Address	City	State	Zip	

Additional Information

Do you take Medications/Supplements? YES ☐ NO ☐ If yes please list. **(Including oral contraceptives, aspirin, over the counter medications, and home remedies)**

_____

_____

Are you Allergic to any Medications? YES ☐ NO ☐ If yes please name. _____

Date of last Eye Exam _____
***Do you wear glasses*?** **YES ☐ NO ☐**
***How Old are your glasses*?** _____
***Do you wear contact lenses*? YES ☐ NO ☐**
Type - Rigid ☐ Soft ☐ Extended Wear ☐ Other ☐
Brand Name - _____

Are you Pregnant? _____
Are you Nursing? _____
Do you use a computer? _____
Any associated problems? _____
Prior Eye Surgery? _____
Prior Eye Injury? _____

Do you currently, or have you ever in the past had any problems in the following areas?

Yes ☐ No ☐ Chronic Infection of the Eyelids
Yes ☐ No ☐ Dizziness
Yes ☐ No ☐ Flashes/Floaters in Vision
Yes ☐ No ☐ Foreign Body Sensation
Yes ☐ No ☐ Itching
Yes ☐ No ☐ Mucus Discharge from Eyes
Yes ☐ No ☐ Redness
Yes ☐ No ☐ Sandy or Gritty Feeling
Yes ☐ No ☐ Seizures
Yes ☐ No ☐ Styes or Chalazion

Do you experience any of the following?

Yes ☐ No ☐ Blurred Vision - Distance near/both
Yes ☐ No ☐ Burning
Yes ☐ No ☐ Distorted Vision/Halos
Yes ☐ No ☐ Double Vision
Yes ☐ No ☐ Dryness of Eyes
Yes ☐ No ☐ Excessive tearing
Yes ☐ No ☐ Eye Pain or soreness
Yes ☐ No ☐ Glare or Light Sensitivity
Yes ☐ No ☐ Headaches
Yes ☐ No ☐ Loss of side vision
Yes ☐ No ☐ Loss of Vision
Yes ☐ No ☐ Tired Eyes

Under 18:

Yes □ No □ Difficult Reading

Yes □ No □ Behind a Grade level in School

Continue on Back Side

*** PAYMENT & INSURANCE CO-PAYMENTS ARE DUE AT TIME OF SERVICE ***

Do you currently, or have you ever in the past had any problems in the following areas?

		Family History
Yes ☐ No ☐	Allergies/Hay fever	
Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Yes ☐ No ☐	Asthma	Yes ☐ No ☐
Yes ☐ No ☐	Autoimmune Disease (arthritis, etc)	
Yes ☐ No ☐	Blindness	Yes ☐ No ☐
Yes ☐ No ☐	Cancer	
Yes ☐ No ☐	Crossed Eyes	Yes ☐ No ☐
Yes ☐ No ☐	Diabetes I or II _____	
Yes ☐ No ☐	Emphysema	Yes ☐ No ☐
Yes ☐ No ☐	Glaucoma	
Yes ☐ No ☐	Heart disease	Yes ☐ No ☐
Yes ☐ No ☐	High/Low Blood Pressure	Yes ☐ No ☐
Yes ☐ No ☐	Macular Degeneration	Yes ☐ No ☐
Yes ☐ No ☐	Retinal Detachment/Disease	
Yes ☐ No ☐	Other _____ (Describe)	Yes ☐ No ☐

Confidential Information

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you smoke? **YES** - Light / Moderate / Heavy **NO** Do you drink alcohol? **YES** - Light / Moderate / Heavy **No**

REFERRED BY: (Name & Address) _____

Online _____ Insurance _____ Other_____

PLEASE CHECK ANY ITEMS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR

Contact Lenses ☐ Laser Vision Correction ☐ Computer Glasses ☐ Progressive (no line) Bifocals ☐

Hobby Glasses ☐ Photo Chromic Lenses ☐ Sports Eyewear ☐ Vocational or Safety Lenses ☐

Spare Emergency Glasses ☐ Other ☐ (Explain) _____

IMPORTANT! PLEASE READ AND SIGN

I hereby authorize any necessary treatment by the optometrist in the practice of Quynh Tran Optometry and agree to be responsible for my bill, *including balances not paid by my insurance company* and necessary accounting fees charged to collect late payment of services rendered and goods ordered.

I authorize this office to release any information necessary to expedite insurance claims.

I understand that in the event that I do not pick up my glasses or contacts which I have ordered, leaving an outstanding balance, they may be returned and disassembled for credit (where possible) after 8 weeks following being notified.

I am still liable for the professional fees and for services rendered and non-returnable fee on the above items.

****** I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION ******

Responsible Party Signature **X**	
(1st Visit)	(2nd Visit)
Date	Date

If Minor - Name of Parent _____ ***Emergency Contact*** _____

Acknowledgement of Receipt

*I acknowledge that I received a copy of Queunh Tran Optometry, Notice of Privacy Practices. (*HIPPA*)*

Date: _____ Signature _____