VISION EYE GALLERY

PATIENT INFORMATION

LAST NAME_____FIRST_____BIRTH DATE_____AGE _____M OR F MARRIED Y / N

HOME ADDRESS_____CITY_____STATE_____ZIP_____

CELL PHONE: _____HOME PHONE: _____ EMAIL_____

EMPLOYER/SCHOOL NAME_____OCCUPATION_____APPOINT REMINDERS BY PHONE/TEXT/EMAIL: YES/NO

VISION INSURANCE NAME: _____INSURED'S I.D. #_____D.O.B._____

PRIMARY/ INSURED'S NAME_____PRIMARY SS#_____PT'S RELATION TO INSURED? SELF, SPOUSE, CHILD

HEALTH/MEDICAL INSURANCE NAME_____ID#_____PHONE NUMBER_____

WHAT IS YOUR CHIEF COMPLAINT? _____

EXAM FOR EYEGLASSES, CONTACT LENS OR OFFICE VISIT?_____DO YOU WEAR GLASSES OR OTC? YES/ NO HOW OLD IS YOUR GLASSES?_____

LAST EYE EXAM DATE: _____NAME OF PREVIOUS EYE DOCTOR? _____HOW DID YOU HEAR ABOUT US?_____

DO YOU WEAR CONTACT LENSES? YES / NO WHAT BRAND AND PRESCRIPTION? _____

HOW MANY HRS DO YOU WEAR YOUR CONTACTS?_____/DAY? DO YOU LEAVE YOUR CONTACTS IN OVERNIGHT? YES/ NO HOW OFTEN?_____/WK

PATIENT OCULAR HISTORY? DO YOU OR FAMILY MEMBERS HAVE ANY CURRENT OR PREVIOUSLY DIAGNOSED EYE CONDITIONS?

CURRENT EYE SYMPTOMS? (REDNESS, DISCHARGE, BURNING, ITCHING, TEARING, SUDDEN LOST OR CHANGE IN VISION, SWELLING OF LID OR GROWTH)					YES/ NO
GLAUCOMA?	YES/ NO	LAZY EYE?	YES/ NO	FLASHES?	YES/ NO
MACULAR DEGENERATION?	YES/ NO	RETINAL DETACHMENT?	YES/ NO	FLOATERS?	YES/ NO
CATARACT OR CAT SURGERY	YES/ NO	DRY EYES?	YES/ NO	DOUBLE?	YES/ NO

LIST ANY PAST EYE INFECTION/INJURY (CONJUNCTIVITIS, CORNEAL ABRASION, TRANSPLANT, STYE, ULCER):_____

DO YOU USE ANY EYE DROPS INCLUDING OTC?_____

NAME OF YOUR REFERRING PHYSICIAN_____PHONE NUMBER_____

PATIENT MEDICAL HISTORY: DO YOU HAVE ANY MEDICAL CONDITIONS LISTED BELOW? (PLEASE CIRCLE YES OR NO)

GASTROINTESTINAL (GERD, HEPATITIS)	YES/ NO	NEUROLOGICAL (MS, STROKE)	YES/ NO	CONSTITUTIONAL (FEVER, WEIGHT LOSS)	YES/ NO
EARS/NOSE/THROAT (SINUS)	YES/ NO	GENITOURINARY (BLADDER, KIDNEY)	YES/ NO	BLOOD/ LYMPH (ANEMIC)	YES/ NO
CARDIOVASCULAR (HBP,CHOLESTEROL)	YES/ NO	MUSCULOSKELETAL (ARTHRITIS)	YES/ NO	ALLERGIC/ IMMUNOLOGIC (ALLERGIES)	YES/ NO
RESPIRATORY (COPD, ASTHMA)	YES/ NO	INTEGUMENTARY (SKIN)	YES/ NO	HEADACHES/ MIGRAINE	YES/ NO
HEMATOLOGIC/ LYMPHATIC (PROSTATE)	YES/ NO	PSYCHIATRIC (MENTAL, DEPRESSION)	YES/ NO	FEMALE ONLY: PREGNANT	YES/ NO
ENDOCRINE (DIABETES, THYROID)	YES/ NO	DIABETES TYPE? 1 OR 2 INSULIN OR NONINSULIN		HOW MANY YEARS? _____	

PLEAST LIST ANY OTHER MEDICAL CONDITIONS THAT ARE NOT LISTED ABOVE: YES/NO _____

PLEASE LIST ALL MEDICATIONS (NAMES & HOW OFTEN): YES/NO _____

PAST OPERATIONS (INCLUDING EYE SURGERIES): YES/ NO (TYPE &WHEN) _____

PLEAST LIST ANY ALLERGIC REACTIONS TO MEDICATIONS OR EYE DROPS /DILATION DROPS: YES/ NO:_____

I request that payment of authorized Medicare benefits or other insurances be made on my behalf to Dr. Pauline Nguyen/ Vision Eye Gallery or any services furnished me by that doctor. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services. If your insurance claim has not been paid within 60 days of the date of service, you will be billed and acknowledged this responsibility. SIGN _____

HEALTH INSURANCE PORTABILITY AND PRIVACY ACT OF 1996 (HIPPA) requires that Dr. Pauline Nguyen & Associates, P.A., hereafter referred to as "The Practice", provides you a copy of, or access to, our Notice of Privacy Practices. I acknowledged that I have been presented the opportunity to read the Notice of Privacy Practices. SIGN_____DATE_____

SIGNATURE_____PRINT PARENT'S NAME_____DATE_____