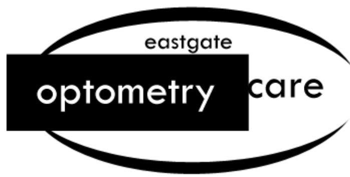

WELCOME

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 INFO

Date________________ **Social Security#**_________________________

Patient Last Name____

First Name_____________________________ Middle Initial_________

Title_________Suffix_________Nickname___________________________

Address____

City_________________________ State________ Zip_____________

Sex ☐ M ☐ F Age________ Birthdate____________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _______ years

Home Phone (_____)____

Work/ Spouse work Phone (_____)____________________ Ext________

Cell Phone (_____)____

Email Address____

Spouse's Name *(optional)*_____________________________________

Birthdate *(optional)*_____________SS# *(optional)*___________________

Who may we thank for referring you?____________________________

Do you have a flexible spending account?_________________________

What is the purpose of this visit?______________________________

(circle) **eye exam / contact lens exam/ LASIK/ RX eyeglasses/ Red Eye Sunglasses/ safety glasses/ Office visit/ Corneal Reshaping Therapy**

INSURANCE

Who is responsible for this account?_________________________

Relationship to Patient____________________________________

Insurance Co.____

Group#____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name____

Birthdate____________________ SS#_______________________

Relationship to Patient____________________________________

Insurance Co.____

Group#____

ASSIGNEMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____ and assign directly to

Name of Insurance Company(ies)

Dr. Hollie Huynh O.D. all insurance benefits, if any otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care 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, Parent, Guardian or Personal Representative

____

Please print name of Patient, Parent, Guardian or Personal Representative

________________________ ________________________

Date Relationship to Patient

EMPLOYMENT INFORMATION

Occupation_________________________________**Patient/ Spouse Employer** ____________________________________

Employer Address______________________________________ Employer Phone (_____)______________________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name____ Relationship____

Home (_____)_____________________ Cell (_____)______________________ Work Phone (_____)____________________ Ext_______

EYE HEALTH HISTORY

Eye Doctor's Name______________________

Date of last eye exam____________________

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Computer ☐ TV

☐ Reading ☐ Driving

Do you wear contacts? ☐ Yes ☐ No

Type___________________________________

How many hours a day?_________________

What solution do you use?________________

Describe any problems you have with your contacts______________________________

____

Place a mark on "Yes" or "No" to indicate if you have had any of the following and if it is a problem:

Condition	Yes	No	Condition	Yes	No
Blurred Vision - Distance	☐ Yes	☐ No	Seeing Floaters	☐ Yes	☐ No
Blurred Vision - Near	☐ Yes	☐ No	Seeing Flashes	☐ Yes	☐ No
Blurred Computer Vision	☐ Yes	☐ No	Poor Night Vision/ Halos	☐ Yes	☐ No
Red Bloodshot Eyes	☐ Yes	☐ No	Double Vision	☐ Yes	☐ No
Discharge from Eyes	☐ Yes	☐ No	Dizzy Spells, Blackouts	☐ Yes	☐ No
Burning Eyes	☐ Yes	☐ No	Headaches or Migraines	☐ Yes	☐ No
Watering Eyes	☐ Yes	☐ No	Crossed Eyes/ Lazy eye	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No	Poor Color Vision	☐ Yes	☐ No
Itching Eyes	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Light Sensitivity	☐ Yes	☐ No	Cataracts	☐ Yes	☐ No
History of Eye Infections	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No
Eye Strain	☐ Yes	☐ No	Retinal Detachment	☐ Yes	☐ No
Twitching Eyelid	☐ Yes	☐ No	Diabetic Retinopathy	☐ Yes	☐ No
Eye Injury Date_________	☐ Yes	☐ No	Eye surgery Date________	☐ Yes	☐ No

Kind of eye injury________________________ Type of surgery__________________________

-OVER-

MEDICAL INFORMATION & FAMILY HISTORY

Physician's Name________________________________ Date or year of last visit________________________

Place a circle around the word to indicate if you have had any problems with these systems.

High Blood Pressure	High Cholesterol
Heart Condition	Endocrine glands
Gastrointestinal	Blood/ Lymph (Anemia)
Ears / Nose / Throat	Allergic/ Hay Fever
Asthma/ Lung Disease	Headaches
Mental Disabilities	Nervous system/ Epilepsy
Urinary-kidney Disease	Eye Disease
Integumentary-Skin	Shingles
Thyroid Disease	Tuberculosis
Hepatitis	HIV/ AIDS/ STD
Stroke	Diabetes Type ________________
Cancer	Other ________________

Any surgeries? __________ Type & When ________________

Pease mark if you participate in the following sport/ hobby/ or recreation.

Basketball	☐ Yes	☐ No
Golf	☐ Yes	☐ No
Jogging	☐ Yes	☐ No
Fishing / Boating	☐ Yes	☐ No
Skiing / Snowboarding	☐ Yes	☐ No
Surfing/ Water sports	☐ Yes	☐ No
Soccer	☐ Yes	☐ No
Shooting	☐ Yes	☐ No
Baseball/ Softball	☐ Yes	☐ No
Plumbing	☐ Yes	☐ No
Mechanic	☐ Yes	☐ No
Sewing / Scrapbooking	☐ Yes	☐ No

Other ________________________________

Are you pregnant?_____

Number of children ____

Tobacco Use _________

Alcohol Use __________

Family History (please circle yes or no and indicate the immediate family relation)

High Blood Pressure	Yes	No	Relation ____________	Diabetes	Yes	No	Relation ______________
Heart Condition	Yes	No	Relation ____________	Cataracts	Yes	No	Relation ______________
Retinal Detachment	Yes	No	Relation ____________	Glaucoma	Yes	No	Relation ______________
Macular Degeneration	Yes	No	Relation ____________	Cancer	Yes	No	Relation ______________

MEDICATIONS

List any medications you are currently taking, including eye drops:

____

____

____

____

____

ALLERGIES

List your allergies to medications or other substances? Yes No

Which?____

____

____

Reactions?_____________________________________

____

HIPPA

In the course of providing service 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 you have been given 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 Care. A Professional Corp.

Signature____ Date________________________________

MEDICARE AUTHORIZATION (if applicable)

I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. Hollie Huynh O.D. for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and their agents any information needed to determine these benefits or benefits for related services.

Signature of Benfeciary, Guardian or Personal Representative______________________________ Date________________

Please print name of Benfeciary, Guardian or Personal Representative__________________________ Date________________

DOCTOR USE ONLY

Reviewed By ________________________________ No changes Date ________________________

Reviewed By ________________________________ No changes Date ________________________