Vista Optometry Center | Dennis Lin O.D. - 537 S. Atlantic Blvd. Monterey Park, CA 91754 - 323-264-2015

Patient Information Questionnaire

Today's Date_____/____/______ **Age_______**

Name:____________________________________Birth Date:_____/_____/________Social Security #_______/_______/_______

Address____City:______________________State:_____Zip:___________

Cell Phone: (______)_______-__________Home Phone: (______)_______-_________Work Phone:(______)________-_________

Email:____ Status: ☐ Married ☐ Divorced ☐ Single ☐ Other Gender: ☐ M ☐ F

Language Preference: ☒ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Vietnamese ☐ Other:____________________

How did you hear about us /Who referred you?____

Occupation________________________________Hobbies____

Emergency Contact: (In case we are unable to contact you)(If under 18, parent or guardian info needed)

Name:_______________________________________ Phone:____________________________Relationship:_________________

Last Physical Exam_____/_____/______Name of Medical Doctor:_____________________Dr.'s Phone: (_____)______________

Last Eye Exam _____/____/______ Name of Eye Doctor:_________________________Dr's. Phone: (_____)______________

INSURANCE: Vision and Medical PPO Insurance

Vision Insurance Name:_______________________________**Vision** Insurance Policy Number:____________________________

Primary's Name__________________________ Primary's SSN:_____________________ Primary's Birthdate:_______________

Medical Insurance Name(**PPO only**):_____________________**Medical** Ins. Policy Number:_______________________________

Primary's Name__________________________ Primary's SSN:_____________________ Primary's Birthdate:_______________

I certify that the information given by me is true and correct. I certify that I, and/or my dependent(s) have insurance coverage and authorize payment of these benefits directly to Dennis Lin, O.D., Inc. on my behalf for any services and materials furnished. 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. 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 to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Lifetime Patient Signature or legal representativeX_______________________________________Date___________________
(Used for insurance claim submission for this office only)

HIPPA

I acknowledge the Notice of Privacy Practices(All patients will receive a copy) X_______________________Date:____________

MEDICAL HISTORY

Do you have any allergies to medication? ☐No ☐ Yes If yes, explain____

____

List any medications you take (including oral contraceptives, pills, eye drops, vitamins, over the counter medications, etc.):

____

____

____

List all major injuries, surgeries and/or hospitalizations you have had and when?_______________________________________

____

Check any of the following that you have had: **If None to All, Check here:** ☐

☐ Crossed eyes ☐ Lazy eye ☐ Macular degeneration ☐ Loss of vision ☐ Dry eyes ☐ Allergy eyes ☐ Glaucoma
☐ Cataract ☐ Retinal disease ☐ Eye infections ☐ Eye injury ☐ Others:__________________________________

Are you pregnant and/or nursing? ☐ No ☐ Yes
Do you wear eye glasses? ☐ No ☐ Yes If yes, how old is your present pair of eyeglasses?__________________________
Do you wear contact lenses? ☐ No ☐ Yes If yes, what brand and power?____

Last Name:____________________________ First Name:______________________ M.I.__ DOB:_____________

FAMILY HEALTH AND EYE HISTORY

Check any **FAMILY HISTORY** (parents, grandparents, siblings, blood relative) for the following conditions.
IF YES? WHO? PLEASE INDICATE RELATIONSHIP. **If None to All. Check here**: □

□Cataract_________________	□Retinal Disease___________	□High Cholesterol__________	□Kidney Disease______
□Glaucoma_________________	□Blindness_______________	□Thyroid Disease___________	□Cancer_____________
□Macular Degeneration________	□Diabetes________________	□ Arthritis_______________	□Lupus _____________
□Crossed Eye/Lazy Eye________	□Heart Disease_____________	□Other:__________________	□Other:_____________
□Diabetic Retinopathy_________	□High Blood Pressure__________		

SOCIAL HISTORY

Do you smoke? □ No □ Yes, how long:___________ Do you drive □ No □Yes, how long:___________
Do you drink alcohol? □ No □ Yes, how long:___________ Do you use illegal drugs? □ No □Yes, how long:___________
Have you ever been exposed to or infected with an STD: □ No □ Yes If yes: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

REVIEW OF SYSTEMS OF PATIENT MEDICAL HISTORY

Do you currently, or have you ever had any problems in the following areas: **PLEASE CHECK THE APPROPRIATE BOXES.**

System	NO	YES	?
Constitutional			
Fever, Weight Loss/Gain	□	□	□
Integumentary (Skin)	□	□	□
Neurological			
Headaches	□	□	□
Migraines	□	□	□
Seizures	□	□	□
Eyes*			
Loss of Vision	□	□	□
Blurred Vision			
Far, Near, Computer	□	□	□
Seeing Glare/Halos	□	□	□
Loss of Side Vision	□	□	□
Double Vision	□	□	□
Dryness/Burning	□	□	□
Watery Tearing Eyes	□	□	□
Mucous Discharge	□	□	□
Redness	□	□	□
Sandy or Gritty Feeling	□	□	□
Itchy Eyes	□	□	□
Foreign Body Sensation	□	□	□
Light Sensitivity	□	□	□
Eye Pain	□	□	□
Chronic Infection of Eye or Lid	□	□	□
Styes or Chalazion	□	□	□
Flashes/Floaters in Vision	□	□	□
Tired Eyes/ Eyestrain	□	□	□
Endocrine			
Thyroid/Other Glands	□	□	□

System	NO	YES	?
Ear, Nose, Mouth, Throat			
Allergies/Hay Fever	□	□	□
Sinus Congestion	□	□	□
Runny Nose	□	□	□
Chronic Cough	□	□	□
Respiratory			
Asthma	□	□	□
Chronic Bronchitis	□	□	□
Emphysema	□	□	□
Vascular/Cardiovascular			
Diabetes	□	□	□
High Cholesterol	□	□	□
High Blood Pressure	□	□	□
Vascular Disease	□	□	□
Heart Pain	□	□	□
Gastrointestinal			
Diarrhea	□	□	□
Constipation	□	□	□
Genitourinary			
Genitals/Kidney/Bladder	□	□	□
Bones/Joints/Muscles			
Rheumatoid Arthritis	□	□	□
Muscle	□	□	□
Joint Pain	□	□	□
Lymphatic/Hematologic			
Anemia	□	□	□
Bleeding Problems	□	□	□
Allergic/Immunologic	□	□	□
Psychiatric	□	□	□
Anxiety/Depression	□	□	□

If you have a condition not listed, please explain & list medications:

____
____
____

Doctor's Signature(Reviewed)______________________Date________ **Patient's** Signature(Reviewed)____________________Date________
Doctor's Signature(Reviewed)______________________Date________ **Patient's** Signature(Reviewed)____________________Date________
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