OPTIC GALLERY

Today's Date _____/_____/______
Patient's Name ____ Gender **(M/F)** ____ **Age**____ **Date of Birth** ____/____/______
Married **(Y/N)** ___ **Name of Insured** ____________________________ **Insured's S.S.#** ______-________-____________
If Child, Parent's Name ___________________________ S.S. # _______-_______-________ D.O.B. _____/_____/______
Address ____ City _______________ State ______ Zip ____________
Phone ______-_______-________ Cell _______-_______-_______ Business Phone _______-_______-_______
Place of Employment/School _________________________________ Occupation ____________________________
Medical Insurance _________________________ **Member ID** _________________ **Patient's Email** ____________________
Vision Insurance ____________________________ Secondary Vision Insurance ________________________
List Activities/Hobbies ____
Date of Last Eye examination: ______/______/________ Where __________________________ Doctor ____________________
Do you wear contact lenses? **(Y/N)** ___ Type _______________ Are you interested in wearing contact lenses? **(Y/N)** ___
Reason for Today's visit: ____
How were you referred to our office? ____

MEDICAL HISTORY:

Medical Doctor ____________________ Last visit _______________ Phone _____-_______-_________

Do you have (Past or Present)?

___Heart Disease ___Diabetes ___Major Illness
___Hypertension ___Lung Disease ___Surgery
___Kidney Problems ___Cancer ___Sickle Cell
___Ulcers ___Asthma ___Cholesterol
___Thyroid Problems ___Sinus Problems ___Other
___Headaches ___Allergies

Do you: Smoke ___ Drink ___ Use Drugs__
Medications: ________________________
____
____
____

Does anyone in your family have?

___Diabetes ___Cancer ___Hypertension
___Heart Disease ___Lung Disease ___Other

Allergies: ________________________
____

OCULAR HISTORY:

Do you have (Past or Present)?

___Glaucoma ___Blurred Vision ___Flashes ___ Watering ___Trauma
___Cataracts ___Double Vision ___Eye Fatigue ___Redness ___Surgery
___Blindness ___Floaters ___Itch ___Eye Turn ___Dry Eye

Does anyone in your family have?

___Glaucoma ___Blindness ___Macular Degeneration ___Eye Disease ___Other

IF APPLICABLE I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE BE MADE EITHER TO ME OR ON MY BEHALF TO OPTIC GALLERY, DR. CHEN YOUNG, OR ANY OF THEIR ASSOCIATES FOR ANY SERVICES RENDERRED TO ME. I AUTHORIZE PERTINENT MEDICAL INFORMATION ABOUT ME, TO DETERMINE INSURANCE BENEFITS AND BILLING TO BE RELEASED TO THE HEALTH CARE FINANCING OR OTHER INSURANCE AGENCIES.
I UNDERSTAND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY INSURANCE COMPANY.

In the event that it becomes necessary for Optic Gallery to release and/or request your records from another healthcare professional, your written permission is required.
I authorize Optic Gallery, Dr. Chen Young or any of their associates to release and/or request these records.

PATIENT SIGNATURE (Patient or Guardian): ____

It is policy of this office to require:

1. Payment in full or at least one-half before the order can be placed.
2. All balances that are left on the account must be paid in full upon patient/ guardian pick up.
3. **All orders are final when placed.**

PATIENT SIGNATURE (Patient or Guardian): ____ **DATE:** ____/____/_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM AND FOR CHOOSING OUR OFFICE FOR YOUR EYECARE AND VISION NEEDS