



Welcome to Our Office

Date Name Date of Birth Age Gender M F
Address City State Zip
Social Security # Home Ph# Work# Cell#
Email Employer
Whom may we thank for referring you to us? Occupation/Hobbies
Person to contact in case of emergency Relationship Phone #

Insurance Information

Vision Insurance Name of Primary Relationship to Patient
Date of Birth Social Security # Primary Care Physician
Medical Insur. ID # Group #

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Dr. Nguyen 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 hereby authorize the doctor to release all information necessary to secure the payment to benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date

Health History

Reason(s) for today's visit:

Date of your last eye exam: Name of the eye doctor/office:

Do you or anyone in your immediate family have a history of the following? (Please check all that apply)

Table with 2 columns: Ocular Conditions and Health Conditions. Each condition has checkboxes for Self and Family.

Please list any other medical conditions that you have:

Please list all medications you are currently taking:

Please list any allergies that you have:

Do you currently wear eyeglasses? Yes No

If yes, when do you wear your glasses?

- All the time, Reading/near tasks, Work safety, Distant tasks only, Computer Work, Other, please explain

Have you ever worn contact lenses? Yes No

If so, what type of lenses have you worn?

- Daily Wear, Extended Wear, RGP, Disposable lenses, Toric lenses, Colored contacts, Monovision, Bifocal lenses

Are you interested in wearing contact lenses? Yes No

Thank you for choosing us for your eye care and eyewear needs.