PATIENT INFORMATION

Today's Date _____

Name _____ Home Phone _____

Birthdate _____ Age _____ Gender: M____ F____ Cell Phone _____

Address _____ Email _____

City _____ State _____ Zip _____ Occupation _____

Employer/School _____ Employer/School Phone _____

VISION Insurance _____ ID # _____ Social Security Number _____

MEDICAL Insurance _____ ID # _____ Emergency Contact Number _____

Whom may we thank for referring you? _____

MEDICAL & EYE HISTORY

Please indicate below any abnormal conditions you or a family member have, or have had (S = Self, F = Family)

	Yes	No		Yes	No		Yes	No
Endocrine/Diabetes	____	____	Headaches	____	____	Dry Eyes	____	____
Heart/Hypertension	____	____	Eye Injury	____	____	Watery Eyes	____	____
Thyroid	____	____	Eye Surgery	____	____	Lazy Eye	____	____
High Cholesterol	____	____	Floaters	____	____	Light Sensitivity	____	____
Lungs/Asthma	____	____	Glaucoma	____	____	Retinal Disease	____	____
Cancer	____	____	Cataracts	____	____			
Arthritis	____	____						
Immunology	____	____	Do You:					
Depression	____	____	Drink Alcohol?	____	____	How much? _____		
Anxiety	____	____	Smoke?	____	____	How much? _____		

Please list other **Medical Conditions** _____

Please list all **Medications** you are currently taking _____

_____

Please list **Allergies** to any medicines or other things _____

_____

ACCOUNT INFORMATION

Person Responsible for Account _____

Relationship to Patient _____ Phone _____ Driver's License Number _____

ATTESTATION: I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I understand I am financially responsible for all charges whether or not paid by insurance including but not limited to any service considered non-covered, and deductibles and/or co-payments as well as any service denied due to non-participating provider. I assign directly to Dr. Johan Tran all insurance benefits, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

_____ _____

Patient or Parent or Guardian Signature Date