

WELCOME TO EUGENE EYEWEAR, OFFICE OF DR. STEVE JUNG, O.D

Please Print Clearly

Married: _____ Single: _____ Other: _____ Are you currently a Student? Yes _____ No _____

Gender: Male _____ Female _____ Non Binary _____ Birth date: (MM/DD/YYYY) _____ / _____ / _____

Name: _____
Last Legal First Name (Preferred Name) Middle Initial

Address: _____
Street or PO Box Apt Number City State Zip

Preferred Phone: (_____) _____ Alternative Phone: (_____) _____

Who is responsible for the Out of Pocket Costs? _____ Relationship to patient _____

Birthday of responsible party (MM/DD/YYYY) _____ / _____ / _____

Please check only one: _____ I will Self Pay / No Insurance. _____ Bill my insurance.

My last eye exam was _____ year(s) ago (if elsewhere)

I currently wear (circle): Glasses / Soft Contact Lenses / Rigid Gas Permeable Contacts / No Prescription

I am interested in (circle): Glasses Rx / Soft Contact Lenses Rx / Rigid Gas Permeable Contacts Rx / Not Sure

Do you have any medical conditions which may affect the eyes? (Circle)

High Cholesterol / High Blood Pressure / Diabetes / Other _____

Who is your Primary Care Physician (PCP)? / Where are they located? _____

Please list any eye problems / conditions, injuries or diseases you have had: _____

(Cont.) _____

Please list any eye surgeries you have had and the date(s) of surgery: _____

(Cont.) _____

Do you have any immediate family members (grandparent, parent, sibling) who have any eye problems / conditions?

(Circle) Glaucoma / Macular Degeneration / Cataracts / Eye Turn / Lazy Eye / Unknown

List your current medications: _____

Allergies to medications: _____

Please sign and date below if we are billing your insurance. Your signature authorizes the release of medical and other information necessary to process your insurance claim. Your signature also authorizes insurance payments to be sent directly to Dr. Steve Jung, OD at Eugene Eyewear, PC. Insurance companies do not guarantee benefits when we call for coverage estimates. Patients are responsible for all balances after insurance payments. Thank you!

Signature: _____

Today's Date: _____