PLEASE PRINT OUT AND BRING TO YOUR APPOINTMENT

South Coast Optometry
Dr. Daniel E. Quon & Associates

PATIENT REGISTRATION AND HISTORY FORM

Patient Name_______________, ________________________ Spouse's Name____________________________
(Last) (First) (Middle)
If Child, parent's name___________________Nearest Relative & Phone No._____________________________
Address_____________________________________ City__________________State-ZipCode_____________
Home No.(____)___________________**Work No**.(___)_____________________**Cell No**.(___)______________
Fax No._____________________________ **E-Mail** _____________________________________
Date of Birth_____________Age____Sex M / F SS#________________CDL#________________exp._______
Circle One: Married Single Widowed Divorced
How did you hear about us? [ ] Saw in building [ ] Newspaper/Magazine Ad [ ] Insurance referral___________
[ ] Internet________(Circle: Google? Yahoo? SouthCoastOptometry Website? VSP Eyefinity Website?)
[ ]Yellow Pages____(Circle: ATT? Idearc? Yellow Book? Local small directories?)
[ ] **Referred by (person's name)**____

Method of Payment: () Cash () Check () Charge () ATM
Vision Insurance: () VSP (Vision Service Plan) () MES (Medical Eye Service) () Other
() Superior Vision Insurance () EyeMed () Cole or Pearl Vision (Secure Horizon)

Employer Name____Occupation_________________________
Address_________________________________City____________State-Zip Code______________________
Primary Insurance (Health Insurance)_________________________Co-pay Amount______Deductible________
Subscriber's Name____Relation to Patient_________________
Subscriber's Social Security No.__________-__________-__________Group/Policy No.___________________

Secondary Insurance____Co-Pay Amount _____Deductible_______
Subscriber's Name____Relation to Patient_________________
Subscriber's Social Security No.__________-__________-__________Group/Policy No.___________________
Note: All deductibles and/or co-payments are due on date of service.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to **DANIEL E. QUON O.D., INC.** for the benefits otherwise payable to me. I understand that I am responsible for charges not covered by my insurance plan.
SIGNATURE OF INSURED____***DATE***______________

RELEASE OF INFORMATION

I authorize the release of any medical information acquired in the course of my examination or treatment to process insurance claims or further treatment to a referred doctor. I am providing this in compliance with HIPA regulations.
SIGNATURE OF INSURED____***DATE***______________

NOTICE REGARDING ADDITIONAL TESTS AND PROCEDURES

Our eye exams are very complete and detailed with testing lasting typically ½ to ¾ hour long. In event that your standard (intermediate level) eye exam indicates further testing is needed (e.g. dilation, visual field, retinal photos, topography, color vision correction analysis, PRIO computer vision analysis, contact lens evaluation & fitting, etc.), these test take additional time, expertise, equipment utilization, and may require another scheduled appointment. These tests have a fee that may or may not be completely covered by insurances. If you have any questions about these tests or fees, please feel free to ask. After receiving these professional services, you are responsible to pay for these services at the time provided unless your insurance company's protocol states otherwise. As with all our professional services we provide a super-bill to be submitted with any insurance company not regularly accepted by our office for reimbursement and your convenience. I understand & agree to the above notice.
SIGNATURE OF INSURED ____***DATE***______________

PLEASE TURN OVER

PATIENT HISTORY

PURPOSE OF TODAY'S VISIT: ____

Last eye exam date__________ From Dr. ___________ Age of present glasses_____ From Dr. ______________

Have your eyes ever been dilated? * () No, () Yes, When______________________________________

*__Optomap Retinal Evaluation__ is recommended for proper eye health evaluation. There is an additional fee of $49 for this service. Declining this service may allow a condition to go undetected that could possibly lead to loss of vision or undetected physical health problems. I understand the above and desire to **[ ] Have my internal part of my eyes photographed with Optomap, [ ]** I am *Declining* to have my internal eyes photographed with Optomap or **[ ] I prefer to have my eyes DILATED** (which MAYBE covered depending upon insurance)

SIGNATURE____ ***DATE*** _________________

Do you ever see double () No () Yes, When? ____

Are you unusually sensitive to bright light and/or glare? () No () Yes, When? ____________________________

Do you have frequent headaches? () No () yes, where on head (front, back, side, top)? ___________Frequency (hourly, 1xday, 2xday, 3xday, etc)_________Duration (how long do they lasts? Minutes, Hours)___________

Do you have trouble with NIGHT vision? () No () Yes, When? ___________________________________

How many hours a day do you average on a computer monitor? ___________How many hours at one time?_____

How many hours a day do you average on paperwork reading tasks? _______How many hours at one time?_____

What sports and/or hobbies do you do?____

Are you interested in Laser Vision Correction (e.g.LASIK)? () No () Yes

Are you interested in contact lenses? () No () Yes, If yes please complete the following

CONTACT LENS HISTORY:

Do you wear contact lenses? () No, () Yes, Days per week__________ Last Worn_______________________

How old are your current contacts? Right lens__________Left Lens__________Fitted by Dr._______________

Type of contact lens worn: () Hard or Gas Permeable () Soft, yearly type () Soft Toric () Bifocal () MonoVision
() Soft disposable (Circle One: 1-Day? 1wk? 2wk? 1mo? 3mo? 6mo? 1yr?)

Manufacture/Brand Name_________________________ Right Power _________Left Power________

YOUR actual discarding cycle__________________________Brand of solution used: _______________

Method of Wear: () Daily Wear () Extended wear (overnight) () Flexible Wear (infrequent nap)
() Occasional wear (once in a while for social or sports)

HEALTH HISTORY:

Do you or any blood related family members have:

Allergies/Sinus () No () Yes, Who______________ Eye Infections () No () Yes, Who_________________

High Blood Pressure () No () Yes, Who______________ Dry eyes () No () Yes, Who_________________

Heart Disorder () No () Yes, Who______________ Sties or Chalazion () No () Yes, Who_____________

Diabetes/Hypoglycemia () No () Yes, Who____________ Crossed /or Lazy Eyes () No () Yes, Who__________

Thyroid Disorder () No () Yes, Who_______________ Cataract () No () Yes, Who____________________

Epilepsy/Seizures () No () Yes, Who_______________ Glaucoma () No () Yes, Who___________________

Arthritis () No () Yes, Who_______________ Macular Degeneration () No () Yes, Who__________

Lupus () No () Yes, Who_______________ Retinal Detachment () No () Yes, Who____________

Cancer, Leukemia () No () Yes, Who______________ Flashes/Floaters in vision () No () Yes, Who______

Do you have any allergies to any medications? () No () Yes, What_____________________________________

List any **medications** you take (including oral contraceptives, aspirin, over the counter medications and home remedies) with **dosage** and **frequency**: ____
____

List (&date) any major (body or eye) injuries, surgeries, or hospitalizations you have had__________________
____

Are you pregnant and/or nursing? () No, () Yes, How long have you been pregnant/nursing? ______________

SOCIAL HISTORY:

(strictly confidential) You may discuss this portion directly with the doctor if you prefer.

Do you use tobacco products? () No () Yes: Type/Amount/How long? ____________________________________

Do you drink alcohol? () No () Yes: Type/Amount/How long? ____

Do you any recreational/illegal drug () No () Yes: Type/Amount/How Long? ____________________________

Have you ever been exposed to or infected with: () Gonorrhea () Hepatitis () HIV () Syphilis () None