Date ______________

PHAMILY EYE CARE, LLC

Kim Pham, OD

Welcome to our office! Please print all items completely. All information will be strictly confidential.

Patient Information

Name ______________________ Age ________ Date of Birth ____________ Gender ☐M / ☐F

Address ______________________ Cell Phone ______________________

City ____________ State ______ Zip Code __________ Email ______________________

Occupation ______________________ Employer ______________________

Primary Care Physician ______________________ Phone#/Address ______________________

Preferred Pharmacy ______________________ Phone#/Crossroads ______________________

Emergency Contact ______________________ Phone# ______________ Relationship __________

If patient is a minor, guardian name ______________________ Guardian Phone # ______________

Preferred method of communication: ☐Telephone ☐Text ☐E-mail

Patient & Family Medical & Ocular History

Self	Family/Who in the family?		Self	Family/Who in the family?	
☐	☐ ________	Heart Disease	☐	☐ ________	Glaucoma
☐	☐ ________	High Cholesterol	☐	☐ ________	Macular Degeneration
☐	☐ ________	High Blood Pressure	☐	☐ ________	Eye turn/Lazy Eye
☐	☐ ________	Diabetes	☐	☐ ________	Retinal Detachment
☐	☐ ________	Thyroid (hyper/hypo)	☐	☐ ________	Color Blindness
☐	☐ ________	Multiple Sclerosis	☐	☐ ________	Keratoconus
☐	☐ ________	Kidney (hepatitis, dialysis)	☐	Eye Injury: Type/When/Which eye? ________________	
☐	☐ ________	Cancer: ____________	☐	Eye surgery: Type/When/Which eye/Where? ________________	
☐ Arthritis	☐Lupus		☐	Other: ________________	
☐ Asthma	Currently pregnant? ☐Y / ☐N				
☐ HIV/AIDS	Currently smoke? ☐Y / ☐N				

Please list current **medications**	Please list drug **allergies**	**Contact Lens** Wear Schedule
		For current contact lens wearers:
		#Hours/Day of wear: __________
		Replace lens every ________day(s)
	Please list previous **surgeries**	Do you sleep in your contacts? Y/ N
		If so, how many nights/wk? ______
		Cleaning solution:______________
		Brand & prescription if known:
		Right Eye: ______________________
		Left Eye: ______________________
		Interested in colored contacts? Y/ N

→ → → → Please complete back side also → → → →

Review of Systems

Please mark any symptoms you are experiencing ***today***

Eyes
- ☐ blurry vision
- ☐ itchiness
- ☐ burning
- ☐ excess watering
- ☐ pain
- ☐ double vision
- ☐ other: ___________________

Ear/Nose/Throat
- ☐ hearing loss
- ☐ sinus problems
- ☐ sore throat
- ☐ hoarseness
- ☐ other:___________________

Immunologic/Allergic
- ☐ swollen glands
- ☐ frequent infections
- ☐ seasonal allergies
- ☐ other:___________________

Gastrointestinal
- ☐ nausea
- ☐ heartburn
- ☐ abdominal pain
- ☐ diarrhea
- ☐ vomiting
- ☐ other:___________________

Musculoskeletal
- ☐ muscle aches
- ☐ joint pain
- ☐ swollen joints
- ☐ other:___________________

Neurological
- ☐ numbness
- ☐ weakness
- ☐ headaches/migraines
- ☐ paralysis
- ☐ other:___________________

Cardiovascular
- ☐ chest pain
- ☐ irregular heart beat
- ☐ palpitations
- ☐ other:___________________

Constitutional
- ☐ fever
- ☐ unexpected weight loss/gain
- ☐ fatigue
- ☐ other:___________________

Respiratory
- ☐ shortness of breath
- ☐ wheezing
- ☐ coughing
- ☐ other:___________________

Pyschiatric
- ☐ depression
- ☐ anxiety
- ☐ other:___________________

Office Policies

Financial Agreement & Acknowledgement of Receipt of Notice of Privacy Practices

I understand that all services rendered to me and charged are my personal responsibility for timely payment: including co-payments, deductibles, and non-covered services remaining after my insurance has paid. I understand that it's my responsibility to know my insurance coverage. I authorize use of the signature on this form for insurance claim submissions, and for insurance to be filed on my behalf based on the information given on the date of service.

I understand that there are **NO refunds** on professional fees. I understand follow-up visits outside 30 days will incur a fee.

☐ Yes, I understand and agree to the office financial policies and have had my questions addressed.

☐ Yes, I have read or given the opportunity to read the Notice of Privacy Practices.

☐ Yes, I consent to having my electronic signature represent my agreement to all above terms

Insurance Information

Vision Insurance: ☐ None / Self Pay

☐ MES ☐ VSP ☐ Spectera

Policy/ID No. ___________________________

Is patient primary card holder? ☐Y / ☐N

If no, name of primary: ______________________

Primary's birth date: ________________________

Disclosure of Health Information

I authorize release of my health information to the following person(s)/health care provider:

Name ______________________________

Relationship _________________________

Phone/Email ______________________________

Name ______________________________

Relationship _________________________

Phone/Email _________________________

Signature agreeing to all above terms ____ Date ____________________