Today's Date: ______________________

PATIENT INFORMATION

Patient: ____________________________________

Address: ____________________________________

City: ____________________ Zip: ______________

Home Phone: ________________________________

Cell Phone: _________________________________

M ___ F ___ Age: ______ DOB: ______________

Marital Status: single__ married__ widowed__ divorced__ separated__

SSN: ______________________________________

Occupation: _________________________________

Employer: ___________________________________

Work Phone: ________________________________

Email Address:

________________________@__________________

Emergency Contact: ___________________________

Relationship to patient: _______________________

Phone #: ____________________________________

INSURANCE INFORMATION

Primary Ins.: ___________________________________

Group #: _______________________________________

ID #: ____

Guarantor's Name: ______________________________

Relationship to Patient: __________________________

Guarantor's SSN: _______________________________

Guarantor's DOB: _______________________________

Employer of Guarantor: __________________________

Secondary Insurance: ____________________________

Tertiary Insurance: ______________________________

❑ My Primary Insurance is Tricare and I do not have any other insurance.

❑ My Primary Insurance is Medicare and I do not have any other insurance.

My Primary Insurance and Secondary Insurance above are listed completely and accurately to my knowledge.

Signature: _____________________________________

Referring Physician: ____

Is this visit related to an on-the-job injury or an accident? ❑ Yes ❑ No

If yes, date of injury: ________________ Explanation of injury: ______________________________________

I request that payment of authorized benefits be made to Dr. Yue-Kong Au on my behalf, for any services provided to me. I understand that if my insurance company requires a referral or approval of services, it is my responsibility to ensure that it is done prior to the examination with Dr. Au. I agree to pay for all charges not covered by a third party carrier or insurance carrier.

I consent to treatment necessary for the care of patient above. I hereby authorize the release of all medical records to the referring physicians and to my insurance companies.

Signature: ____ Date: ________________________________

Chart # __________

Medical History Record

For faster service, please complete the following form prior to arriving at our office.

Appointment Date: ____________________________

Patient: ________________________________ **Date of Last Eye Exam (If Applicable):** _________________________

Name of Previous Eye Doctor (If Applicable): ____

Do you have a living will? ❑ **Yes** ❑ **No** **General Physician:** _________________________________

Medications You Are Currently Taking:

____
____
____
____
____
____

List Allergies to Medications or Other Substances:

____
____
____
____
____
____

Personal Medical Information: Do you have problems with any of these systems? If Yes, please check box.

❑ Gastrointestinal
❑ Ear/Nose/Throat
❑ Cardiovascular
❑ Respiratory
❑ Headaches
❑ Nervous System
❑ Genitourinary
❑ Musculoskeletal
❑ Skin
❑ Surgeries (what type & when) ____
❑ Mental
❑ Endocrine (Glands)
❑ Blood/Lymph
❑ Allergic/Immunologic

Are you in good health? ❑ Yes ❑ No

Do you have family history of any of the following? If Yes, please check box.

❑ Diabetes
❑ Macular Degeneration
❑ Glaucoma
❑ Retinal Detachment
❑ High Blood Pressure
❑ Cataracts

Please explain any boxes you have checked: ____

____

Do you have any of the following? If Yes, please check box.

❑ Dry Eyes
❑ Blurred Vision
❑ Eye Surgeries
❑ Eye Injuries
❑ Wear Glasses
❑ Wear Contacts

Are there any other eye problems at this time? Please explain: ____

____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature: ____ **Date:** ________________________________