VISION EYE GALLERY

PATIENT INFORMATION

Mr. Mrs. Ms. LAST NAME_____FIRST_____BIRTH DATE_____AGE _____MARRIED Y / N

HOME ADDRESS_____CITY_____STATE_____ZIP_____

CELL PHONE: _____HOME PHONE: _____ WORK PHONE: _____

EMPLOYER'S /SCHOOL NAME_____OCCUPATION_____EMAIL:_____

LAST EYE EXAM DATE: _____ CURRENT GLASSES (age) _____ EYE DOCTOR'S NAME_____

VISION INSURANCE NAME: _____INSURED'S I.D. #_____D.O.B._____

PRIMARY/ INSURED'NAME_____PRIMARY SS#_____PT'S RELATION TO INSURED? SELF, SPOUSE, CHILD

MEDICAL/ HEALTH INSURANCE:_____ID#_____DO YOU HAVE MEDICARE? Y OR N

NAME OF FAMILY DOCTOR _____ DATE OF LAST VISIT _____LAST TETANUS SHOT _____

MEDICAL HISTORY:

DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE SYSTEMS? (PLEASE CIRCLE YES OR NO)

GASTROINTESTINAL	YES / NO	NERVOUS	YES / NO	ENDOCRINE (THYROID)	YES / NO
EARS/NOSE/THROAT	YES / NO	URINARY	YES / NO	BLOOD/ LYMPH	YES / NO
CARDIOVASCULAR	YES / NO	MUSCLES/ BONES	YES / NO	ALLERGIC/ IMMUNOLOGIC	YES / NO
RESPIRATORY	YES / NO	INTEGUMENTARY (SKIN)	YES/ NO	HEADACHES	YES / NO
HIGH BLOOD PRESSURE	YES/ NO	EYES	YES/ NO	MENTAL	YES / NO

DIABETES YES/NO TYPE_____ DATE OF DIAGNOSIS_____

ALLGERGIES TO MEDICATION? YES / NO WHICH? _____REACTIONS? _____

HAD ANY OPERATIONS? _____ KIND? _____ WHEN? _____

CURRENT MEDICATION(S) _____

FAMILY HISTORY:

HIGH BLOOD PRESSURE	YES / NO RELATION _____	MACULAR DEGENERATION	YES/ NO RELATION _____
DIABETES	YES / NO RELATION _____	RETINAL DETACHMENT	YES/ NO RELATION _____
GLAUCOMA	YES/ NO RELATION _____	CATARACTS	YES/ NO RELATION _____

PERSONAL EYE INFORMATION

DO YOU HAVE ANY EYE CONDITIONS OR PROBLEMS? YES / NO WHAT KIND? _____

HAVE YOU HAD ANY EYE OPERATIONS? YES / NO TYPE _____DATE _____

DO YOU HAVE ANY GLAUCOMA? YES / NO	CATARACTS? YES / NO	DRY EYES?	YES / NO
MACULAR DEGENERATION? YES/ NO	RETINAL DETACHMENT? YES / NO	BLURRED VISION?	YES/ NO
DO YOU WEAR GLASSES? YES /NO	CONTACT LENSES? YES / NO	IF SO, WHAT TYPE	_____

I request that payment of authorized Medicare benefits or other insurance be made on my behalf to Dr. Pauline Nguyen/ Vision Eye Gallery or any services furnished me by that doctor. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services. If your insurance claim has not been paid within 60 days of the date of service, you will be billed and acknowledged this responsibility. SIGN: _____

HEALTH INSURANCE PORTABILITY AND PRIVACY ACT OF 1996 (HIPPA) requires that Dr. Pauline Nguyen & Associates, P.A., hereafter referred to as "The Practice", provides you a copy of, or access to, our Notice of Privacy Practices. I acknowledged that I have been presented the opportunity to read the Notice of Privacy Practices. SIGNATURE:_____DATE_____

Dilation allows the doctor to exam the structures inside your eyes. You will experience light sensitivity, difficulty focusing at near for 4-6 hours.
◯ YES, I do want my eyes dilated. ◯ NO, I do not want my eyes dilated today and agree to hold the Practice harmless as a result of my action.

SIGNATURE_____ PRINT PARENT'S NAME_____DATE_____