Dawson T. Li, O.D. & Yuh-Jen Liao, O.D.

Welcome to Our Office

So that we can help you best, please fill out <u>both pages</u> legibly and completely. Thank You!

Full Name _____ Today's date _____

Name you go by (if different) _____ Approximate date of last eye exam _____

Home address _____ Date of birth _____ Sex: M F

City _____ State _____ Zip _____ Social security number _____

Home phone ___(_____)_____ Employer (or School) _____

Work phone ___(_____)_____ Occupation (or Grade) _____

Cell phone ___(_____)_____ Emergency contact name _____

E-mail address _____ Emergency contact phone (_____)_____

Name of Family Members at Home	Relationship	Age	Current Patient of Ours?
			Y N
			Y N
			Y N
			Y N

Medical Insurance _____ How will you settle your account today?

Do you participate in a flexible spending account? Y N ❑ Cash ❑ Credit Card

Are you a member of an eye care plan? Y N (if yes, circle your plan below and sign to authorize benefits)

Vision Service Plan (VSP) Medical Eye Services (MES) Eye Med Other _____

I authorize the payment of any eye care benefits indicated above to my Doctor of Optometry. I understand that I may have co-payments and overages (costs not paid for by the eye care plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: _____ Date _____

Personal Medical History

Allergies / Asthma	Y	N	Eye Injury / Surgery	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	High Cholesterol	Y	N
Eye Disease	Y	N	Other_____		

Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)

Are you allergic to any medicines? Y N (If yes, please list)

How did you *first* hear about our office?

❑ Family, friend, or co-worker. Who? _____

❑ Doctor referral. Who? _____

❑ Eye care plan directory.

❑ Yellow pages. Which directory? _____

❑ Internet. Which website? _____

❑ Other. Please specify. _____

_____

Please complete the second page . . .

Welcome to Our Office, Page 2

Family Medical History			
Blindness or Visual Disability	Y	N	Unsure
Cataracts	Y	N	Unsure
Diabetes	Y	N	Unsure
Glaucoma	Y	N	Unsure
High Blood Pressure	Y	N	Unsure
Macular Degeneration	Y	N	Unsure
Other disease (please specify) _____			

Eye Care for Your Lifestyle			
Do you desire glasses that are thinner, lighter, and more comfortable?	Y	N	
Do you spend much time outdoors?	Y	N	
Do you spend much time working on a computer?	Y	N	
Are your eyes very sensitive to bright lights?	Y	N	
Are you bothered by glare and reflections, especially at night?	Y	N	
Are you interested in wearing the most advanced contact lenses?	Y	N	
Would you like to change your eye color?	Y	N	
Are there times you would rather not wear glasses or contact lenses?	Y	N	
Do you suffer from dry eyes?	Y	N	
If you wear prescription glasses, do you have only one pair?	Y	N	N/A
If you wear bifocal glasses, does the line bother you?	Y	N	N/A
If you wear bifocal or progressive glasses, do you ever wish you could wear contacts?	Y	N	N/A

So that we can get to know you better . . . What hobbies, sports, or other activities do you enjoy?

I acknowledge that I have received a copy of Dr. Li & Dr. Liao's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, BakersfieldEyeDoc.com.

Patient name _____ Today's Date _____

Signature of patient (or parent/guardian for minors) _____

Thank you!