Terry K. Isbill O.D.
Paula Vang, O.D.

# PATIENT FORM



## GENERAL INFORMATION

First, MI, Last:

Street Address:

City, State, Zip:

Date of Birth: *Male | Female*

Phone: *home | cell | work* Email:

Preferred Contact Method: *phone | email | text | other (please explain):*

Primary Care Doctor: Primary Care Phone:

Emergency Contact Person: Phone: Relation:

## INSURANCE INFORMATION (skip if self-pay)

***Please present ALL vision and medical insurance cards to receptionist to reduce your out-of-pocket costs and to assist us in referrals.***

Vision Insurance: Primary Member Name:

Primary Member Date of Birth: Primary Member Social Security Number:

Primary Medical Insurance: Primary Member Name:

Insurance ID#: Primary Member Employer:

Your Relationship to Primary Member: *spouse | child | other (please explain):*

Other Insurance?

I hereby authorize Vang Family Optometry to apply for benefits on my behalf for covered services rendered. I also assign my benefits and request that all payments from my insurance(s) are made directly to Vang Family Optometry. I agree to assume responsibility for full payment pending any remaining balance that is not covered by my insurance(s).

I certify that the information I have reported with regard to my coverage is correct. I further authorize Vang Family Optometry to release to my insurance carrier(s) and its agents any information needed to determine payments for related services.

Signature | Relation to Patient (if not self) | Date

## EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

**Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.**
**(M: Mother, F: Father, B: Brother, S: Sister, GP: Grandparent)**

| | | | |
|---|---|---|---|
| Cataracts | *no* | *self* | *M \| F \| B \| S \| GP* |
| Crossed Eye | *no* | *self* | *M \| F \| B \| S \| GP* |
| Glaucoma | *no* | *self* | *M \| F \| B \| S \| GP* |
| LASIK or RK | *no* | *self* | *M \| F \| B \| S \| GP* |
| Lazy Eye | *no* | *self* | *M \| F \| B \| S \| GP* |
| Macular Degeneration | *no* | *self* | *M \| F \| B \| S \| GP* |
| Retinal Detachment | *no* | *self* | *M \| F \| B \| S \| GP* |

# PATIENT FORM



VANG FAMILY OPTOMETRY

**Are you currently experiencing, or have experienced, any of the following? Check all that apply.**

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

## MEDICAL HISTORY

**Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.**

| | | | |
|---|---|---|---|
| AIDS/HIV | *no* | *self* | *M \| F \| B \| S \| GP* |
| Allergies | *no* | *self* | *M \| F \| B \| S \| GP* |
| Arthritis | *no* | *self* | *M \| F \| B \| S \| GP* |
| Asthma | *no* | *self* | *M \| F \| B \| S \| GP* |
| Blood/Lymph Disorder | *no* | *self* | *M \| F \| B \| S \| GP* |
| Cancer | *no* | *self* | *M \| F \| B \| S \| GP* |
| Diabetes | *no* | *self* | *M \| F \| B \| S \| GP* |
| Ears, Nose, Throat Conditions | *no* | *self* | *M \| F \| B \| S \| GP* |
| Gastrointestinal Conditions | *no* | *self* | *M \| F \| B \| S \| GP* |
| Heart Disease | *no* | *self* | *M \| F \| B \| S \| GP* |
| High Blood Pressure | *no* | *self* | *M \| F \| B \| S \| GP* |
| High Cholesterol | *no* | *self* | *M \| F \| B \| S \| GP* |
| Kidney Disease | *no* | *self* | *M \| F \| B \| S \| GP* |
| Lupus | *no* | *self* | *M \| F \| B \| S \| GP* |
| Neurological Conditions | *no* | *self* | *M \| F \| B \| S \| GP* |
| Psychiatric Disorder | *no* | *self* | *M \| F \| B \| S \| GP* |
| Seizures | *no* | *self* | *M \| F \| B \| S \| GP* |
| Skin Conditions | *no* | *self* | *M \| F \| B \| S \| GP* |
| Stroke | *no* | *self* | *M \| F \| B \| S \| GP* |
| Thyroid Dysfunction | *no* | *self* | *M \| F \| B \| S \| GP* |

**If you answered yes to any conditions, please explain (if needed):**

**Current Medications (prescription and over-the-counter and dosage)**

**Medication Drug Allergies**

**Females: Are you pregnant or nursing?** *yes | no*

**Do you smoke?** *yes | no*

How much?

**Have you ever smoked?** *yes | no*

**Do you drink alcohol?** *yes | no*

How much?