Patient Demographic & Health History Form

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. Cell Phone: ___ - ___ - ____

PATIENT'S NAME:

Last: ______________ First: ______________

Marital Status: ☐ M ☐ S ☐ W ☐ D ☐ Sep ☐ Other Sex: ☐ Male ☐ Female

Mailing Address: ______________

City: ______________ State: __ Zip Code: _____ - ____

Birthdate: __ - __ - ____ Age: ___ CA DLic #: ________

E-Mail: ______________ @ ______________

Social Sec. # : ___ - __ - ____ Home Phone #: ___ - ___ - ____

Occupation: ______________ Employer: ______________

Address: ______________ Work Ph #: ___ - ___ - ____

Spouse: ______________ Spouse Phone: ___ - ___ - ____

In case of emergency or appointment change, may we have the following information?

Name of nearest friend or relative not living with you: ______________

Relationship: ______________

Phone Day: ___ - ___ - ____ Phone Night: ___ - ___ - ____

Name of family (PCP) Doctor: ______________ City/State: ______________

Name of Optometrist: ______________ City/State: ______________

Referred by: ______________ May we send a thank you card? ☐ Yes ☐ No

☐ Physician ☐ Optometrist ☐ Friend ☐ Insurance Co. ☐ Internet ☐ Television ☐ Radio

☐ Newspaper ☐ Phone Book ☐ Other: ______________

PRIMARY INSURANCE COMPANY: ______________

Subscriber: ______________ ID #: ______________

Group #: ______________ Policy #: ______________

SECONDARY INSURANCE COMPANY: ______________

Subscriber: ______________ ID #: ______________

Group #: ______________ Policy #: ______________

ASSIGNMENT OF BENEFITS:

I hereby irrevocably authorize: ______________

to make payment directly to Center for Sight of any insurance benefits otherwise payable to me, for professional services rendered to date, but not to exceed the stated charges for these services. I understand that I am responsible for any charges not paid by my insurance company, and for any charges not paid within sixty (60) days of billing to said insurance company. A copy of this authorization shall be valid as the original.

Release of Information: I hereby authorize Center for Sight to furnish and disclose all known facts concerning my care to my insurance company and to other physicians upon my request. A copy of this authorization shall be as valid as the original.

Patient Signature: ______________ Date: __ - __ - ____

Keith Liang, M.D. Health Questionnaire

1. Please list any eye drops you are currently taking. (Please note dosage): ______________________

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2. Are you allergic to any medications? If yes, what medications, and what effect do they have on you?

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3. Are you allergic to adhesive tape? ☐ Yes ☐ No
4. Are you allergic to iodine? ☐ Yes ☐ No
5. Do you drive a vehicle? ☐ Yes ☐ No
6. Do you use recreational drugs? ☐ Yes ☐ No
7. Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? ______________
8. Do you drink alcohol? ☐ Yes ☐ No If, yes, how often? ☐ Daily ☐ Weekly ☐ Monthly
9. Have you ever had any major surgery or illnesses? ☐ Yes ☐ No If yes, please list and note date of any surgery/surgeries:

Date: ☐☐ - ☐☐ - ☐☐☐☐ Surgery Type: ______________________

Date: ☐☐ - ☐☐ - ☐☐☐☐ Surgery Type: ______________________

Date: ☐☐ - ☐☐ - ☐☐☐☐ Surgery Type: ______________________

Date: ☐☐ - ☐☐ - ☐☐☐☐ Surgery Type: ______________________

Date: ☐☐ - ☐☐ - ☐☐☐☐ Surgery Type: ______________________

10. Have you ever had a blood transfusion? ☐ Yes ☐ No

11. Check any of the following illnesses and/or surgeries you have had:

☐ Diabetes	☐ Chest Pain
☐ Heart Murmur	☐ Tuberculosis
☐ Palpitations	☐ Emphysema
☐ Bronchitis	☐ Arthritis
☐ Kidney Disease	☐ Fainting Spells
☐ Drug Addiction	☐ Heart Disease
☐ Nerve Paralysis	☐ Heart Attack
☐ Blood Disorders	☐ Stroke
☐ Thyroid Disease	☐ Hepatitis
☐ High Blood Pressure	☐ Epilepsy (seizures)
☐ Frequent Headaches	☐ ______________
☐ Asthma or Wheezing	☐ ______________
☐ Back Pain / Problems	☐ ______________
☐ Easy Bruising or Bleeding	
☐ Abnormal Shortness of Breath	

12. List all medication(s) you are taking showing medicine name/frequency and dose:

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Patient Signature (or legal Guardian): ______________________ Date: ☐☐ - ☐☐ - ☐☐☐☐