Patient Demographic & Health History Form

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. Sex: ☐ Male ☐ Female

PATIENT'S NAME:

Last: _____ First: _____

Marital Status: ☐ M ☐ DP ☐ S ☐ W ☐ D ☐ Sep Cell: ( ) _____

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): _____

_____

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

_____

_____

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
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Shortness of Breathe
- ☐ Asthma or Wheezing
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Easy Brusing/Bleeding
- ☐ Blood Disorders
- ☐ Frequent Headaches
- ☐ Nerve Paralysis
- ☐ Fainting Spells
- ☐ Epilepsy (seizures)
- ☐ Back Pain/Back Problem
- ☐ Arthritis
- ☐ Drug Addiction
- ☐ _____
- ☐ _____
- ☐ _____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature (or legal Guardian): _____ Date: _____