Keith Liang, M.D. Center for Sight SACRAMENTO, CALIFORNIA

PATIENT DEMOGRAPHIC & HEALTH HISTORY FORM

PATIENT'S NAME: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. Sex ☐ Male ☐ Female

Last ______________________ First ______________________

Marital Status ☐ M ☐ S ☐ W ☐ D ☐ Sep Cell (____)______________

Mailing Address ______________________

City ______________________ State ________ Zip Code ____________ - __________

Birthdate ______________ Age ________ CA DLic # ______________

Email Address ______________________ @ ______________

Social Sec. # ________ - ________ - ____________ Home Phone (_____)______________

Occupation ______________________ Employer ______________________

Address ______________________ Work Phone (_____)______________

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 payments 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. Center for Sight
SACRAMENTO, CALIFORNIA

HEALTH QUESTIONNAIRE

Please list any eye drops you are currently taking. (Please note dosage) ______________________________

____

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

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____

Are you allergic to adhesive tape? ☐ Yes ☐ No Are you allergic to iodine? ☐ Yes ☐ No

Do you drive a vehicle? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes per day? ______________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly

Have you ever had any surgery, including eye surgery? ☐ 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 ______________________________

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

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

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

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

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Patient Signature (or legal Guardian) ______________________________ Date ____________