WELCOME TO DR. TONY PHAN'S OFFICE

Name: ____________________________________**DOB:** _____________ **Age:** ____**Today's Date:** __________

Address: _____________________________________ **City:** _______________ **State:** _____ **Zip:** ___________

Phone: Cell or Work (Daytime) ___________________________ **Sex:** M / F **Marital Status:** Single / Married

SS # _____-_____-_____ **Email:** _______________________________ **Employer:**________________________

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***Supply BOTH your Vision and Medical/Health insurance below for our files:**

Vision Insurance Name & ID: ____

Policy Holder Name ☐ **self :** ___________________________ **SS #** _____-_____-_____ **DOB:** _________

Medical/Health Insurance Name & ID: ____

Policy Holder Name ☐ **self :** ___________________________ **SS #** _____-_____-_____ **DOB:** _________

Reason for today's visit: ____

Please check any conditions below that apply to **YOURSELF** or **FAMILY** members:

OCULAR HISTORY	Self	Family
Distance vision blurred	☐	☐
Near vision blurred	☐	☐
Eye turn (Strabismus)	☐	☐
Lazy eye	☐	☐
Dry eyes	☐	☐
Glaucoma	☐	☐
Macula Degeneration	☐	☐
Excess tearing/watering	☐	☐
Floaters/ Flashes of light	☐	☐
Double vision	☐	☐
Eye surgery/ Injury	☐	☐
Vision Therapy	☐	☐
Halos around lights	☐	☐
Blindness	☐	☐
Decreased night vision	☐	☐
Itchy eyes	☐	☐
Retinal disease	☐	☐
Other(s)_____________________		

MEDICAL HISTORY	Self	Family
Headaches	☐	☐
Migraines	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Multiple Sclerosis	☐	☐
Depression	☐	☐
Sinusitis	☐	☐
Seasonal Allergies	☐	☐
Lupus	☐	☐
Asthma	☐	☐
Arthritis	☐	☐
Gastro/Intestinal	☐	☐
Kidney disease	☐	☐
High Cholesterol	☐	☐
Psoriasis	☐	☐
Other(s) _____________________		

Date of last eye exam: __________________

Have you been seen by Dr. Phan before? Y/N

Do you currently wear glasses? Y/N

Do you currently wear contact lenses? Y/N

Do you smoke? Y / N / In the past

Allergies: ______________________________

Eye drops: ______________________________

Meds: _________________________________

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Pregnant: YES NO

OFFICE POLICY

1. In the event my insurance provider determines that I am not eligible for visual insurance coverage or eligible for a reduced level of coverage, by signing this statement I hereby agree to be financially responsible for any and all charges incurred by me and not paid by my insurance provider.
2. I acknowledge receipt of a copy of Dr. Tony Phan's Notice of Privacy Practice. (below this form)
3. I understand all fees of services rendered are due and payable at the time of service.
4. I understand fees paid for services are non-refundable.

PATIENT SIGNATURE ______________________________ **DATE**___________________