PATIENT INFORMATION

Last Name ________________ First Name ________________ Middle Initial ______ ❑ M ❑ F Birth Date / /

Address ________________________ City ______________ State ______ Zip ________

Home Phone ( ) ______________ Work Phone ( ) ______________ Cell Phone ( ) ______________

Employer ________________ Occupation ______________ Marital Status ❑ married ❑ single

Email Address ________________ Referral Source ____________ Social Security # ____________

INSURANCE INFORMATION

Plan Name ______________ Group # ____________

Insured Name ____________ Insured ID # ____________ Insured Date of Birth ____________

Patient's Relationship to Insured ❑ self ❑ spouse ❑ child

OCULAR AND MEDICAL HISTORY

What is the reason for today's exam? ________________________________

Date of Last exam / / From Dr. ________________________________

Do you or anyone in your family have any of these conditions?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
Diabetes	❑	❑	❑	Cataracts	❑	❑	❑	Do you see double?	❑	❑
High Blood Pressure	❑	❑	❑	Glaucoma	❑	❑	❑	Frequent Headaches	❑	❑
Heart Disease	❑	❑	❑	Retinal Disease	❑	❑	❑	Are you pregnant?	❑	❑
Thyroid Problems	❑	❑	❑	Eye Surgery	❑	❑	❑	Eyes been dilated?	❑	❑
Respiratory Disease	❑	❑	❑	Eye Injury	❑	❑	❑	which year ______		
Cancer	❑	❑	❑	Other	❑	❑	❑	Primary Care Doctor ________		

Are you taking any type of medication? Yes ❑ No ❑

If yes, which ones & for what purposes? ________________________________

Do you have any allergies, medications, or others? Please explain.

____

CONTACT LENS INFORMATION

Do you wear contact lenses now? Yes ❑ No ❑ If yes, what type? ________________

Have you ever worn contact lenses? Yes ❑ No ❑ If yes, what type? ________________

Are you interested in contact lenses? Yes ❑ No ❑ If yes, what type? ________________

Would you like your glasses to be:

	YES	NO		YES	NO
Thinner/Lighter	❑	❑	Line Bifocal	❑	❑
Glare Free	❑	❑	No Line Bifocal	❑	❑
Impact Resistant	❑	❑			
Darken in the sun	❑	❑			

over ⟶

NOTICE OF PRIVACY PRACTICES

To be completed by the individual receiving the Notice of Privacy Practices

I, ____ , acknowledge that I have received a Privacy Practices Notice from Liang Eye Care, P.C..

Signature ____ Date ___________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following

Personal Representative Name: ____

Relation to Individual ____

IMPORTANT! Please Read And Sign

1. **DILATED EYE EXAMINATION INFORMATION** Dilation is a medical procedure, which allows the doctor to use eye drops to temporarily enlarge your pupils for a more extensive view of the retina (back of the eye). With dilation, the doctor has the opportunity to evaluate and diagnose eye health problems before symptoms occur. It is recommended that all new patients are dilated and again every 2 to 4 years thereafter, unless certain conditions require closer monitoring. Some patients may experience light sensitivity and blurred vision for 2-6 hours. If you do not have dark sunglasses for your travel home, we will provide you with a disposable pair. You may have difficulty driving after the procedure, but if you feel more comfortable being driven, please make arrangements to do so.

   In rare instances, patients may experience pain or other side effects. If this should occur, please **seek medical attention** immediately. Please advise our optometrist if you are pregnant or nursing at this time. If you have any other health conditions that may effect your response to these tests or questions regarding dilation, please consult our doctor for additional information.
2. **PAYMENT POLICY** Payment for eye examinations, contact lens examinations, contact lens checks and continuing eye care plans is required at time services are provided. A deposit of 100% is required to order eyeglasses or contact lenses.
3. **PAYMENT POLICY AFTER INSURANCE** 100% of patient balance is required after insurance benefit is applied.
4. **AUTHORIZATION OF PAYMENT AND PATIENT RELEASE I authorize the direct payment of medical/vision benefits to the physician and supplier for services rendered.**

   I accept financial responsibility for any unpaid balances not covered by my Vision Care Program for services rendered to me, my spouse, and/or my dependents. I authorize the release of any medical or other information necessary to process this claim.

I HAVE READ AND UNDERSTAND STATEMENTS 1-4

Patient's Signature ____

Guardian Signature ____