Welcome to the office of Dr. Olivia Le and Associates (**Your information will remain confidential per HIPAA policy**)

Name: _____ **Date:**_____
First Middle Last
Street Address: _____ **Apt #**____ **City** _____ **State** _____ **Zip** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Date of Birth: _____ **Age:** _____

Email Address: _____

Sex: ❑ Male ❑ Female **Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Occupation (or Grade):_____ **Employer (or School):**_____

If minor, PARENT/GUARDIAN name: _____

Who may we thank for telling you about our office? _____

The name of your Medical Doctor is: _____

Personal Eye History

What is the reason for your visit today? _____

Do you have any of the following problems? ❑ Eye Irritation/Infection ❑ Glare
❑ Floater/flashes ❑ Blurred vision ❑ Eye itchiness ❑ Headaches ❑ Other _____

When was your last exam? (Approximately) _____**Doctors Name/ Location**: _____

Do you wear GLASSES? ❑ Yes ❑ No **If YES, do you have them with you TODAY?** ❑ Yes ❑ No

When do you wear your GLASSES? ❑ Full time ❑ Part time ❑ Reading ❑ Distance/ Driving ❑ Computer Use ❑ Safety

Describe your Computer use: ❑ Extensive (5+ hrs/day) ❑ Moderate (1-4 hrs/day) ❑ Low (1hr/day or less) ❑ Seldom ❑ Never

Had any Eye surgery: ❑ None ❑ Lasik ❑ RK ❑ Cataract ❑ Retina ❑ Glaucoma ❑ Eyelid ❑ Other _____

If you wear CONTACTS, please answer: **Lens Type**: ❑ Soft Disposable ❑ Soft Yearly ❑ Color ❑ RGP (Hard)
❑ Monovision ❑ Bifocal/Multifocal ❑ For Astigmatism

If you know the Brand and Power of your contacts, please indicate: _____

Do you sleep with your CONTACTS? ❑ Yes ❑ No **How often do you replace your lenses with new lenses?** _____

Any other problems with your contacts? _____

If you have an Eye Infection or an Irritation, please answer these questions:

Which eye? ❑ Both ❑ Right eye ❑ Left eye **For how long?** _____
What have you done to treat your eye? _____ **Name any drops you used:** _____
Did something get into your eye? ❑ yes ❑ no **If yes, what were you doing?** _____

OFFICE USE ONLY

		IOP	TRIAL CL
DFE	❑ Yes ❑ No	OD _____	OD _____
PHOTO	❑ Yes ❑ No	OS _____	OS _____

CONTINUED ON BACK

Personal Medical History (Many general medical conditions affect the eye and your vision)

Do you take any prescription or non-prescription medicines regularly? ❑ yes ❑ no If yes, please list all medicines:

_____

Do you have any medication allergies: ❑ None known ❑ Penicillin ❑ Sulfa drugs ❑ Other: _____

Do you have problems with the following medical systems? (Please check all that apply in each box)

Constitutional ❑ **None** ❑ Weight loss ❑ Fatigue ❑ Trauma ❑ Fever ❑ Cancer ❑ Other _____	**Neurological** ❑ **None** ❑ Multiple sclerosis ❑ Epilepsy ❑ Other _____	**Gastrointestinal** ❑ **None** ❑ Crohn's disease ❑ Colitis ❑ Ulcer ❑ Digestive concern ❑ Other _____
Allergic/Immunologic ❑ **None** ❑ Drug allergy ❑ Environmental Allergy ❑ Rheumatoid arthritis ❑ Lupus ❑ Others:_____	**Endocrine** ❑ **None** ❑ Type 1 Diabetes ❑ Thyroid Dysfunction ❑ Type 2 Diabetes ❑ Hormonal Dysfunction	**Musculoskeletal** ❑ **None** ❑ Fibromyalgia ❑ Muscular dystrophy ❑ Osteoarthritis ❑ Other _____
Cardiovascular ❑ **None** ❑ Heart disease ❑ Stroke ❑ Vascular disease ❑ High Blood Pressure ❑ High cholesterol	**Blood/Lymphatic** ❑ **None** ❑ Anemia ❑ Leukemia ❑ Other _____	**Integumentary / Skin** ❑ **None** ❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Other _____
Genitourinary ❑ **None** ❑ Urinary tract infections ❑ Kidney concerns ❑ STD: Herpes, Chlamydia, HIV	**Psychiatric** ❑ **None** ❑ Depression ❑ Panic Disorder ❑ Schizophrenia ❑ Other _____	**Respiratory** ❑ **None** ❑ Asthma ❑ Bronchitis ❑ Emphysema ❑ Other
Ears, Nose & Throat ❑ **None** ❑ Upper respiratory tract infection ❑ Other		

❑ **Please check this box if you Do Not have any medical conditions.**

Family Medical History

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

❑ None
❑ Blindness _____
❑ Cataracts _____
❑ Glaucoma _____
❑ Macular _____
❑ Retinal _____
❑ Corneal Disease_____
❑ Lazy Eye_____
❑ Diabetes _____
❑ Heart Disease_____
❑ Hereditary Disease _____
❑ Other Eye Disorders _____

Social History

Use tobacco? ❑ Yes ❑ No **Alcoholic Beverages?** ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No **Breast feeding?** ❑ Yes ❑ No

Insurance Information Release

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Dr. Le, O.D. to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information to pertinent to my case to any third party, adjuster or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Dr. Le, O.D. directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services.

Signature_____ **Date**_____

Acknowledgment of Privacy and Voluntary Consent Form

In providing services to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you and conduct healthcare operations involving our office. The *Notice of Privacy Practices* posted in our office describes these uses and disclosures in detail. Please refer to this notice any time prior to signing this Consent Form. Copies are available for your personal documents.

I have read this Receipt and Consent Form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare options.

_____
Signature

If you are signing as a personal representative of the patient, please indicate your relationship to the patient and print your name.

Relationship to patient **Print Name**

_____ _____

_____ _____/_____/_____
Doctor's Initials Date