Today's Date: ______________________

PATIENT INFORMATION	INSURANCE INFORMATION
Patient: ____________________	Primary Ins.: ____________________
Address: ____________________	Group #: ____________________
City: ____________ Zip: __________	ID #: ____________________
Home Phone: ____________________	Guarantor's Name: ____________________
Cell Phone: ____________________	Relationship to Patient: ____________________
M ___ F ___ Age: ______ DOB: __________	Guarantor's SSN: ____________________
Marital Status: single__ married__ widowed__ divorced__ separated__	Guarantor's DOB: ____________________
SSN: ____________________	Employer of Guarantor: ____________________
Occupation: ____________________	Secondary Insurance: ____________________
Employer: ____________________	Tertiary Insurance: ____________________
Work Phone: ____________________	❑ My Primary Insurance is Tricare and I do not have any other insurance.
Email Address: ________________@____________	❑ My Primary Insurance is Medicare and I do not have any other insurance.
Emergency Contact: ____________________	My Primary Insurance and Secondary Insurance above are listed completely and accurately to my knowledge.
Relationship to patient: ____________________	
Phone #: ____________________	Signature: ____________________

Referring Physician: ______________________________

Is this visit related to an on-the-job injury or an accident? ❑ Yes ❑ No

If yes, date of injury: ______________ Explanation of injury: ______________________________

I request that payment of authorized benefits be made to Dr. Yue-Kong Au on my behalf, for any services provided to me. I understand that if my insurance company requires a referral or approval of services, it is my responsibility to ensure that it is done prior to the examination with Dr. Au. I agree to pay for all charges not covered by a third party carrier or insurance carrier.

I consent to treatment necessary for the care of patient above. I hereby authorize the release of all medical records to the referring physicians and to my insurance companies.

Signature: ______________________________ Date: ______________________

Chart # __________

Medical History Record

For faster service, please complete the following form prior to arriving at our office.

Appointment Date: ______________________________

Patient: __________________________________ **Date of Last Eye Exam (If Applicable):** ___________________________

Name of Previous Eye Doctor (If Applicable): ____

Do you have a living will? ❑ **Yes** ❑ **No** **General Physician:** ___________________________________

Medications You Are Currently Taking:

____
____
____
____
____
____

List Allergies to Medications or Other Substances:

____
____
____
____
____
____

Personal Medical Information: Do you have problems with any of these systems? If Yes, please check box.

❑ Gastrointestinal	❑ Nervous System	❑ Mental
❑ Ear/Nose/Throat	❑ Genitourinary	❑ Endocrine (Glands)
❑ Cardiovascular	❑ Musculoskeletal	❑ Blood/Lymph
❑ Respiratory	❑ Skin	❑ Allergic/Immunologic
❑ Headaches	❑ Surgeries (what type & when) ____	

Are you in good health? ❑ Yes ❑ No

Do you have family history of any of the following? If Yes, please check box.

❑ Diabetes	❑ Glaucoma	❑ High Blood Pressure
❑ Macular Degeneration	❑ Retinal Detachment	❑ Cataracts

Please explain any boxes you have checked: ____

____

Do you have any of the following? If Yes, please check box.

❑ Dry Eyes	❑ Eye Surgeries	❑ Wear Glasses
❑ Blurred Vision	❑ Eye Injuries	❑ Wear Contacts

Are there any other eye problems at this time? Please explain: ____

____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature: ____ **Date:** _________________________________