WELCOME TO BRYAN MA, O.D. OPTOMETRY

Patient Registration and Health History **Date:_____**

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. ☐ Child

Name:_____ Gender: M / F Age:____ Birthdate: _____
Parent's Name (if patient is a minor)_____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Phone: Home (_____)_____ Cell (_____)_____ Work (_____)_____
Email:_____ Occupation: _____ Employer:_____
How did you hear about us? ☐ Friends/ Family ☐ Insurance ☐ Website ☐ Walk-In ☐ Other:_____
Emergency Contact: Name:_____ Relationship:_____ Phone: (____) _____

Insurance Information (if applicable):

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent Insured's date of birth: _____

Insured's Name: _____ Insured's Employer: _____

Insured's ID#: _____ Insurance Plan Name: _____ Auth. No.:_____

☐ **Please check this box if there have been no changes to your medical and ocular history since your last visit.**

Personal Eye/ Medical History

What is the reason for seeking vision care? _____

_____

Visual symptoms (check each you have): ☐ None, routine eye examination

☐ Blurred distance vision	☐ Eye strain	☐ Seeing flashing lights/floaters
☐ Blurred near vision	☐ Headaches related to eyes	☐ Temporary loss of vision
☐ Burning eyes	☐ Itching eyes	☐ Twitching eyelids
☐ Double vision	☐ Light sensitivity	☐ Variable vision
☐ Dry eyes	☐ Red eyes	☐ Watery eyes

Do you or your immediate family have any of the following medical or eye conditions?: ☐ None

Self	Family	Whom?		Self	Family	Whom?		Self	Family	Whom?	
☐	☐	_____	Arthritis	☐	☐	_____	Gastrointestinal	☐	☐	_____	Migraines/Headaches
☐	☐	_____	Asthma	☐	☐	_____	Glaucoma	☐	☐	_____	Macular Degeneration
☐	☐	_____	Blindness	☐	☐	_____	Heart Condition	☐	☐	_____	Poor Color Vision
☐	☐	_____	Cancer	☐	☐	_____	High Blood Pressure	☐	☐	_____	Skin Conditions
☐	☐	_____	Cataracts	☐	☐	_____	Kidney Problems	☐	☐	_____	Thyroid Condition
☐	☐	_____	Diabetes	☐	☐	_____	Lazy Eye (amblyopia)	☐	☐	_____	Tuberculosis

When was your last eye exam? _____ Last Physical? _____ Name of Physician:_____

Are you pregnant? ☐ Y ☐ N Are you currently nursing? ☐ Y ☐ N

Are you presently taking any medication or drugs? ☐ Y ☐ N. If yes, which drugs are you taking? _____

_____

Are you allergic to any medications? ☐ Y ☐ N If yes, which? _____

Have you had any serious eye injuries, eye disease or eye surgery? ☐ Y ☐ N

If yes, please explain: _____

Do you smoke, consume alcohol, or use recreational drugs? ☐ Y ☐ N If yes, please explain: _____

PLEASE TURN PAGE OVER **Dr. Initials _____**

Lifestyle Questionnaire

Do you wear ☐glasses? What type?: ☐Full Time ☐Distance Only ☐Reading Only ☐Computer ☐Safety

Please list any problems you are having with your current glasses _____

☐contact lenses? What type? ☐Soft disposable ☐ Hard If soft, what brand? _____

Please list any problems you are having with your current contacts _____

Are there any times when glasses get in the way of your activities, hobbies, or work? ☐Y ☐N

If yes, would you like to discuss contact lens options today with the doctor? ☐Y ☐N

What are your hobbies? _____

Do you play sports? ☐Y ☐N If yes, please list:_____

Are you currently using sunglasses to protect your eyes from UV exposure? ☐Y ☐N

Do you use the computer? ☐ Y ☐ N If yes, how many hours a day? _____

Do you experience the following during or after computer use? (check all that apply)

☐eye strain ☐glare ☐red eyes ☐blurry vision ☐headaches ☐dry eyes

Are you interested in LASIK? ☐Y ☐N If yes, would you like the doctor to discuss the options with you today? ☐Y ☐N

******INFORMATION REGARDING DILATION******

Dilation is a necessary component of a comprehensive eye examination. The purpose of dilation is to perform a thorough check of the structures inside the eye. Eye drops are instilled which will enlarge the pupils. This will cause blurred vision close up and light sensitivity. It is recommended to have a driver with you if you feel uncomfortable to drive afterwards. Dilation typically lasts 4 to 6 hours, although it is not uncommon for it to last up to 24 hours for some patients, depending on the eye drops used.

A $30 fee will be assessed if not covered by insurance.

_____ YES, I would like to have my eyes dilated today.

_____ NO, I decline to have my eyes dilated today, but I will make an appointment at a later date

_____ NO, I decline to have my eyes dilated today. I understand that without dilation, a condition with the potential for partial or total loss of vision may exist and go undetected.

Patient Initials _____

******PAYMENT IS REQUIRED AT THE TIMES SERVICES ARE RENDERED******

I authorize payment of medical benefits to Bryan Ma, O.D. Optometry. I understand that I am financially responsible to Bryan Ma, O.D. Optometry for all charges whether or not paid by insurance. I authorize Dr. Bryan Ma, O.D. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand Bryan Ma, O.D. Optometry reserves the right to charge a fee of $25.00 for any dishonored checks.

Initials _____

Due to the Health Insurance Portability and Accountability Act (HIPAA), we are obligated by law to give you notice of our privacy practices. Our HIPAA notice is on the following page. I acknowledge that I have read and understand Bryan Ma, O.D. Optometry's Notice of Privacy Practices, and will be given a copy per my request.

Initials_____

Patient or Guardian signature:_____ Date:_____

Dr. Signature_____