Alicia Valencia Eyecare Center of Optometry

Welcome To Our Office

Welcome to Alicia Valencia Eyecare Center. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female

First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State ____ Zip ____

Social Security Number ____ Date of Birth ____ Home Phone – Include Area Code ____ Work Phone ____

Email Address ____ Spouse or Parent(s) Name ____ Person Responsible for Account ____

Emergency Contact ____ Emergency Phone ____

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) ____
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor (Please Name) ____

VISION INSURANCE INFORMATION

Name and Address of Primary Insurance Company ____ City ____ State ____ Zip ____

☐ M ☐ F Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

MEDICAL INSURANCE INFORMATION

Name and Address of Secondary Insurance Company ____ City ____ State ____ Zip ____

☐ M ☐ F Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured Patient Status ☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

I, the undersigned, request that any insurance benefits be assigned to Dr. Nguyen and I understand that I am financially responsible for any and all charges, whether or not paid by insurance. This includes any reasonable costs of collection in the event of default and billing fees charged for accounts beyond 60 days past due. I hereby authorize Dr. Nguyen to release all information necessary to secure the payment of benefits, as well as the use of this signature on all insurance submittals. AVEC will attempt to bill my primary insurance, however, it is my responsibility to bill any secondary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processes. Payment is due at the time of service and at least 50% non-refundable deposit is due before any glasses and/or contacts will be ordered. There will be a service charge of $25.00 on all returned checks.

Signature ____ Date ____

Name Record Test

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MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation:______________________ Years __________ Employer ______________

SPECTACLE LENS HISTORY

Do you use a computer? ☐ Yes ☐ No How many hours/day?________ Distance from Computer? ________

Do you drive? ☐ Yes ☐ No Do you have glare problems? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No

Do you have problems with night vision? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No Since ______________________

Type of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses Owned

☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Back-up Glasses

☐ Safety Glasses ☐ Sports Glasses ☐ Progressive

Have you had trouble in the past with glasses? ☐ Yes ☐ No ______________________________

Do you wear sunglasses? ☐ Yes ☐ No Are your sun glasses your current prescription? ☐ Yes ☐ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints, or coatings) ☐ Safety Glasses (gardening, woodworking, welding)

☐ Occupational (Mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY ☐ **N/A**

Have you ever tried to wear contact lenses? ☐ Yes ☐ No Reason for stopping?____________________

Do you currently wear contact lenses? ☐ Yes ☐ No Since ______________________

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Type and brand of contact lenses ______________________ Today's wearing time? ______________________

How many hours/day?______________________ How many days/week? ______________________

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right | Left		Right | Left		Right | Left
Lens Comfort	____________	Distance Vision	____________	Near Vision	____________

What Solution do you use? Cleaner ______________ Disinfectant ______________ Enzyme ______________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ☐ Yes ☐ No

Do you engage in regular exercise? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much/often: ☐ No ☐ Occasional ☐ 1 per day ☐ 2-3/day ☐ 4+/day

Do you smoke? ☐ Yes ☐ No

If yes, how much/often: ☐ No ☐ Occasional ☐ 1/2 pack/day ☐ 1 pack/day ☐ 1+ pack/day

Method of Tobacco Intake: ☐ Smoking ☐ Chewing

Do you use Illegal Drugs: ☐ Yes ☐ No

Are you planning to get new eyeglasses today? ☐ Yes ☐ No

Are you interested in learning more about laser surgery? ☐ Yes ☐ No

Any question or comment for the doctor today?____

Hobbies/Interests:____

Name Record Test

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PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

____
Primary Care Physician and Clinic Name

____
Address of Primary Care Physician | City | State | Zip | Phone

HEALTH HISTORY

What is the main reason for today's exam? ____________________ When was your last exam? ____________________

When was your last health exam? ____________________

Past Illness or Injuries: ____________________ ____________________

Past Surgeries: ____________________ ____________________

Current Medications: ____________________ ____________________

____________________ ____________________

Current Eye Drops: ____________________ ____________________

____________________ ____________________

Medicines that cause reactions or sensitivities: ____________________

Specific Allergies: ____________________

EYE HISTORY (*check all that apply*)

Glaucoma ☐	Dryness ☐	Strabismus (Crossed Eyes) ☐
Cataract ☐	Excess Tearing/Watering ☐	Blurred Vision Distance ☐
Macular Degeneration ☐	Eye Pain or Soreness ☐	Blurred Vision Near ☐
Retinal Detachment ☐	Foreign Body Sensation ☐	Distorted Vision (halos) ☐
Color Blindness ☐	Infection of Eye or Lid ☐	Double Vision ☐
Headaches ☐	Itching ☐	Floaters or Spots ☐
Glare/Light Sensitivity ☐	Mucous Discharge ☐	Fluctuating Vision ☐
Tired Eyes ☐	Drooping Eyelid ☐	Loss of Vision ☐
Amblyopia (Lazy Eye) ☐	Redness ☐	Loss of Side Vision ☐
Burning ☐	Sandy or Gritty Feeling ☐	Example Glaucoma ☐

GENERAL HEALTH CONDITION (*check all that apply*)

Fever ☐	Respiratory (Asthma) ☐	Anxiety or Depression ☐
Weight Loss ☐	Gastrointestinal ☐	Endocrine (Thyroid, Diabetes) ☐
Other Symptoms ☐	Kidney ☐	Blood/Lymph ☐
Ears, Nose, Throat ☐	Muscles, Bones, Joints ☐	Allergic ☐
Cardiovascular (High Blood pressure etc.) ☐	Skin ☐	Are you? ☐ Pregnant ☐ Nursing
	Neurological (Multiple Sclerosis) ☐	

FAMILY HISTORY (*check all that apply and indicate family member*)

Amblyopia (Lazy Eye) ☐ ________	Retinal Detachment ☐ ________	High Blood Pressure ☐ ________
Blindness ☐ ________	Strabismus (Eye Turn) ☐ ________	Kidney Disease ☐ ________
Cataract(s) ☐ ________	Arthritis ☐ ________	Lupus ☐ ________
Color Blindness ☐ ________	Cancer ☐ ________	Stroke ☐ ________
Glaucoma ☐ ________	Diabetes ☐ ________	Thyroid Disease ☐ ________
Macular Degeneration ☐ ________	Heart Disease ☐ ________	Others ☐ ________

Kim O. Nguyen, O.D.

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ACKNOLEDGEMENT OF RECEIPT OF DR. KIM O. NGUYEN'S NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among any number of multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that Dr. Nguyen has the right to change its notice from time to time and that I may contact this office at any time at the address above to obtain a current copy of it.

I understand that I may request in writing that Dr. Nguyen restricts how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Dr. Nguyen is not required to agree to my requested restrictions, but if she does agree, she is bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient ______________________________

Signature ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of receiving our Notice of Privacy Practices, but was unable to do so as documented below.

Date: __________ Initials: _________ Reasons: ______________________________