Scripps Ranch Optometric Center
Richard N.V. Phung, O.D.
9880 Hibert St., E-1
San Diego, CA 92131

WELCOME TO OUR OFFICE!

Name (Last, First): _____ Date of Birth: _____

Address: _____
(Street) (City) (State) (Zip Code)

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

SSN: _____ Nationality: _____

How were you referred to our office?

☐ Insurance ☐ Coupon ☐ Previous Patient
☐ Newspaper ☐ Walk-in ☐ Family/ Friend _____

Health Insurance (NOT VISION)

Insurance Name: _____ Policy #: _____
Policy Holder's Name: _____ Date of Birth: _____
SSN (last 4 digits): _____ Relationship to Patient: _____

If patient is a DEPENDENT, please complete the following information for the parent or guardian.

Name: _____ Relationship to Patient: _____
Address: _____ Phone #: _____

E-mail Consent and Disclaimer

Our office offer patients the convenience of e-mail for communication. However, transmitting patient information via e-mail poses several risks, which you must be aware of. These include, but are not limited to: e-mail is not secure; e-mail can be easily falsified; e-mail can be forwarded and intercepted by others; e-mail is indelible; etc. Our office will use reasonable means to protect the security and confidentiality of e-mail information sent and received, but we cannot guarantee total security and will not be liable for improper disclosure of confidential information. E-mail should only be used for non-sensitive and non-urgent issues such as routine follow-up inquiries, appointment scheduling, receipts, etc. Please sign below and provide an e-mail address if you still wish to communicate via email under the risks and conditions previously mentioned.

Signature: _____ Email: _____

HIPAA Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices from Dr. Richard N.V. Phung on the date indicated below.

Patient: _____ Date: _____

Signature: _____

Relationship to Patient (if signed by parent/ guardian/ representative): _____

Assignment and Release

I certify that the above information is correct, and I understand that I am financially responsible for all charges, whether or not paid by insurance. Payment is due at the time services are rendered. I hereby authorize the release of any information necessary to secure the payment of benefits and the use of this signature on all insurance submissions. I have read the foregoing, and I am the patient, the patient's guardian or authorized representative to execute this agreement and accept its terms.

Signature: _____ Date: _____

I am giving permission to my family member, relative, or a friend to pick up my glasses or contact lens. ☐ Yes ☐ No
Names: _____

Signature: _____ Date: _____

MEDICAL HISTORY RECORD

Please complete the form. Do not leave anything blank.

Patient's Name (Last, First): _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

Date of Last Eye Exam: _____ Previous Eye Doctor: _____

Primary Care Physician: _____ Phone #: _____

WHAT DO YOU WEAR?

☐ Glasses: Distance / Near / Multifocal ☐ Contacts (Brand): _____ ☐ None/ 1st Exam

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS?

☐ Dry Eyes or Pain: Right Eye / Left Eye / Both Eyes ☐ Blurred Vision: Distance / Near / Both

☐ Floaters _____ ☐ Flashes of Light _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No How much? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____

Do you use other substances? ☐ Yes ☐ No What and how much? _____

PERSONAL MEDICAL HISTORY

Are you allergic to any medications or other substances? ☐ Yes. _____ ☐ No

Are you currently taking any medications (prescription / OTC, artificial tears/ eye drops, vitamins)? ☐ Yes ☐ No

If yes, please list medications and their usage. _____

_____

Ladies, are you pregnant or breastfeeding at this time? ☐ Yes ☐ No

Have you been diagnosed with any of the following? Please *check* all that apply & write the *diagnosis* *date* next to each condition.

☐ Healthy	☐ Surgeries (what types & when): _____		
Ocular:	☐ Cataract	☐ Glaucoma	☐ Macular Deg.
	☐ Eye Injury	☐ Eye Surgery	☐ Lazy Eye
Cardiovascular:	☐ High Cholesterol	☐ Hypertension	☐ Stroke
Endocrine:	☐ Diabetes	☐ Thyroid	☐ Liver
Neurology:	☐ Headaches	☐ Multiple Sclerosis	☐ Seizures
Immunology:	☐ Arthritis	☐ Lupus	
Skin Disorders:	☐ Rosacea	☐ Eczema	
Respiratory:	☐ Asthma	☐ Allergy	☐ Bronchitis
Blood/Lymphatic:	☐ Bleeding Disorder	☐ Cancer	
Psychiatric:	☐ Insomnia	☐ Depression	☐ Anxiety
Constitutional:	☐ Fever/Chills	☐ Weight Gain	☐ Weight Loss
Genitourinary:	☐ Kidneys	☐ Bladder	
Gastrointestinal:	☐ Diarrhea	☐ Constipation	

FAMILY MEDICAL HISTORY - Please *check* all that apply to your *blood relatives* & write the *relationship* next to each condition.

☐ Diabetes	☐ Glaucoma	☐ Macular Deg.	☐ None
☐ Hypertension	☐ Cataracts	☐ Retinal Detachment	

DILATION REFUSAL

It is highly recommended to have your pupils dilated in order for the doctor to evaluate the internal ocular health of your eyes to rule out common eye conditions such as cataract, glaucoma, macular degeneration, and other eye diseases. Your vision might be blurry up to 6 hours, especially close up. Your eyes will also be very sensitive to light and outdoors. Most people can drive home with their sunglasses or the provided disposable shade after dilation. If your are unsure, you may bring a driver and reschedule for your next appointment. Please sign below if you refuse to have your eyes dilated today.

Signature: _____ Date: _____

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

Signature: _____ Date: _____